Florida Jurisdictional HIV Prevention Plan

2015-2016 Update

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Overview of Epidemiologic Data

The Florida Department of Health (FDOH), Bureau of Communicable Disease, HIV/AIDS Section collects, analyzes and disseminates surveillance data on HIV infection. These surveillance data are one of the primary sources of information on HIV and AIDS in Florida. For instance, HIV and AIDS surveillance data are used by the FDOH's public health partners in other health departments, federal agencies, nonprofit organizations, academic institutions and the general public to help focus prevention efforts, plan services, allocate resources and monitor trends in HIV infection. This annual report summarizes information about HIV infection cases and HIV infection cases classified as AIDS in Florida.

Interpretation of HIV/AIDS Data

All HIV/AIDS data are current as of December 31, 2013.

- HIV infection reporting represents newly reported HIV cases, regardless of AIDS status at time of report.
- HIV infection cases and AIDS cases by year of report are NOT mutually exclusive and CANNOT be added together.
- Frozen databases of year-end data are generated at the end of each calendar year. These are the same data used for Florida Community Health Assessment Resource Tool Set (CHARTS) and all grant-related data where annual data are included.
- HIV prevalence data are generated later in the year, usually in July, when most of the estimated death data are complete.
- Adult cases represent ages 13 and older, pediatric cases are those younger than the age of 13.
- For data by year, the age is by age of diagnosis.
- For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.
- Unless otherwise noted, race/ethnicity reference to white residents and black residents represent persons who are white non-Hispanic and black non-Hispanic, respectively. Also, all references to Hispanic for race/ethnicity represent persons of Hispanic heritage regardless of race.
- Total statewide data will include Department of Correction Cases (DOC) unless otherwise noted. County data will exclude DOC cases.
- HIV incidence estimates are approximations of the numbers of people who are newly infected, which include those whose infection has not yet been diagnosed or reported.

HIV/AIDS Exposure Mode Categories are as follows:

- MSM = Men who have sex with men
- IDU = Injection Drug User
- MSM/IDU = Men who have sex with men and injection drug user
- Other = Includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks
- NIR = Cases reported with No Identified Risk

- Redistribution of NIRs = This illustrated the effect of statistically assigning (redistributing) the NIRs to recognize exposure (risk) categorized by applying the proportions of historically reclassified NIRs to the unresolved NIRs.

Florida's Rank in the United States

According to the Centers for Disease Control and Prevention (CDC), Florida ranked second among states in the number of cases of human immunodeficiency virus (HIV) infection diagnosed in 2011 (which is the most recent year data are available nationally).[3] That year, a total of 5,973 (12% of the U.S. total) HIV Infection cases were diagnosed in California, followed by 5,408 (11%) in Florida and 5,065 (10%) in Texas (Table 1). Additionally, Florida ranked third among states in the rate of HIV infections per 100,000 population. That year, Florida (28.4 per 100,000) was ranked behind Maryland (30.6) and Louisiana (30.2).

Table 1. Top States in the Number of HIV Infection Cases, and Rates per 100,000 in 2011

Ranking	State	No. of cases	% of US Total	Ranking	State	Rate per 100,000
1	California	5,973	12%	1	Maryland	30.6
2	**Florida**	5,408	11%	2	Louisiana	30.2
3	Texas	5,065	10%	3	**Florida**	28.4
4	New York	4,960	10%	4	Georgia	25.7
5	Georgia	2,522	5%	5	New York	25.5

Source: CDC. (2013). *HIV Surveillance Report*, 2011; vol. 23.

Florida ranked third among states in the estimated number of acquired immune deficiency syndrome (AIDS) cases diagnosed in 2011.[3] That year, a total of 3,623 (11% of the U.S. total) AIDS cases were diagnosed in California, followed by 3,574 (11%) in New York and 3,440 (11%) in Florida. With regard to the rate of AIDS cases per 100,000 population, Florida (18.1 per 100,000) ranked fourth behind Georgia (22.8), Maryland (20.1), Louisiana (18.4) and New York (18.4) in 2011 (Table 2).

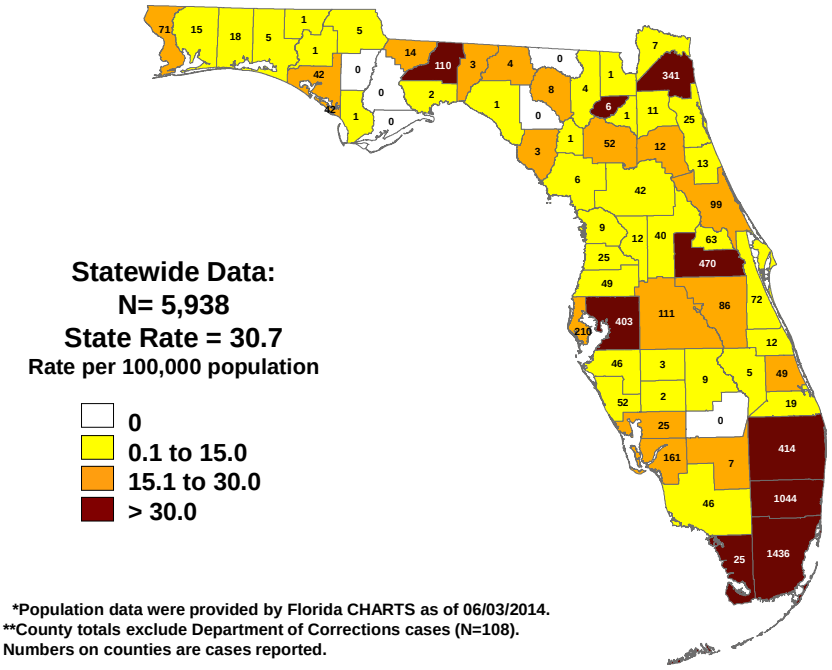
Table 2. Top States in the Number of AIDS Cases, and Rates per 100,000 in 2011

Ranking	State	No. of cases	% of US Total	Ranking	State	Rate per 100,000
1	California	3,623	11%	1	Georgia	22.8
2	New York	3,574	11%	2	Maryland	20.1
3	**Florida**	3,440	11%	3	Louisiana	18.4
4	Texas	3,393	11%		New York	18.4
5	Georgia	2,234	7%	4	**Florida**	18.1

Source: CDC. (2013). *HIV Surveillance Report*, 2011; vol. 23.

In 2013, at least one HIV Infection case was reported in all but six counties in Florida. Ten counties reported 100 or more cases (Figure 1). These ten counties included Broward, Duval, Hillsborough, Lee, Leon, Miami-Dade, Orange, Palm Beach, Pinellas and Polk. These aforementioned counties reported a combined total of 4,230 cases, or 71% of Florida's total reported cases in 2013 (N=5,938). The greatest numbers of HIV cases were reported from Miami-Dade (n=1,436), Broward (n=1,044), and Orange (n=470). These three counties reported a combined total of 2,950 cases in 2013, or half (50%) of the statewide total.

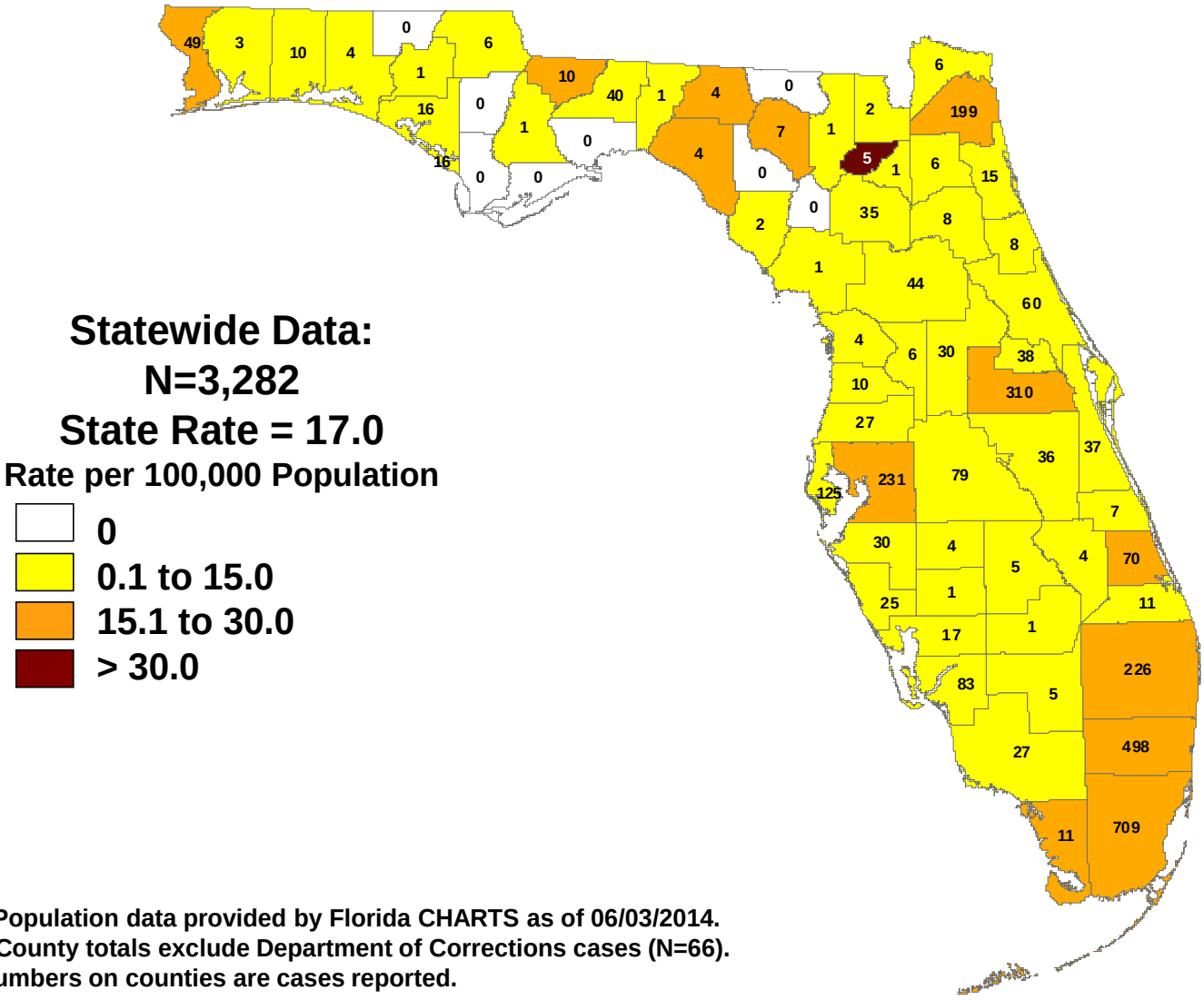
Figure 1. HIV Infection Case Rates* by County of Residence,** Reported in 2013, Florida



AIDS Case Rates by County of Residence

In 2013, at least one AIDS case was reported in all but eight counties in Florida (Figure 2). Although the AIDS epidemic is widespread throughout Florida, the majority of cases were reported from seven counties: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas, all reporting over 100 cases in 2013. These seven counties reported a combined total of 2,298 cases, or 70% of Florida's total reported cases in 2013 (N=3,282). The greatest numbers of AIDS cases were reported from two counties located in the southeastern part of the state, Broward (n=498) and Miami-Dade (n=709). These two counties reported a combined total of 1,207 cases in 2013, 37% of the statewide total.

Figure 2. AIDS Case Rates* by County of Residence,** Reported in 2013, Florida

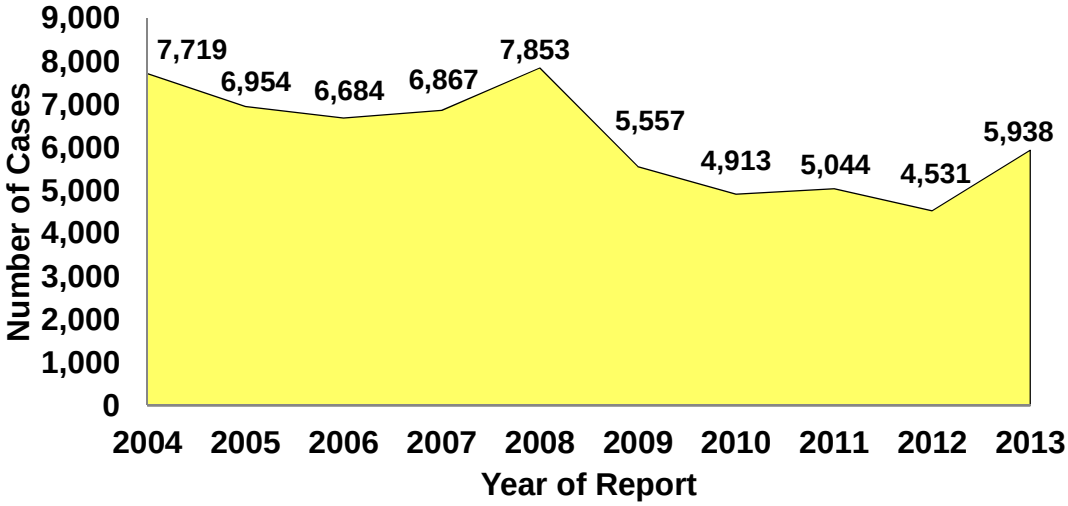


***Population data provided by Florida CHARTS as of 06/03/2014.**
****County totals exclude Department of Corrections cases (N=66).**
Numbers on counties are cases reported.

Ten Year Trend of HIV Infection Cases and Rates by Year of Report

Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of HIV infection in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of HIV infection in 2013 (Figure 3).

Figure 3. HIV Infection Cases and Rates,* by Year of Report, 2004-2013, Florida



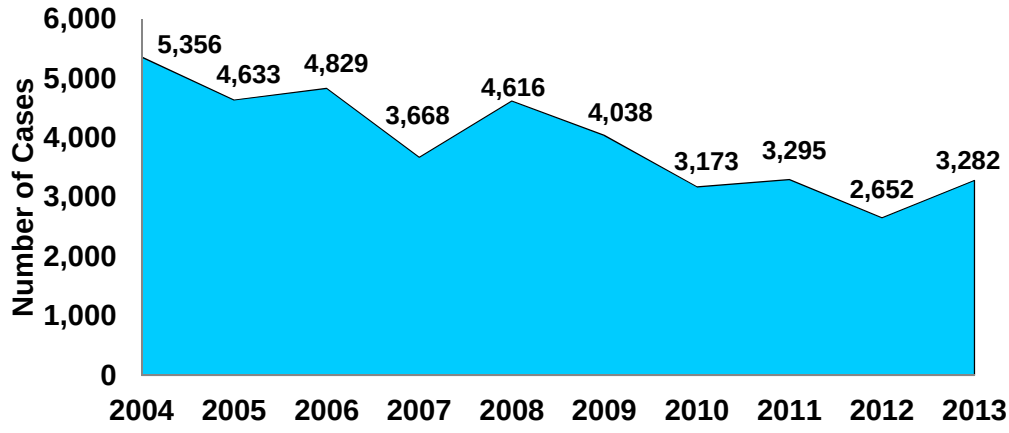
Year	Rate
04	44.2
05	38.9
06	36.6
07	37.1
08	42.1
09	29.7
10	26.1
11	26.6
12	23.8
13	30.7

*Source: Population estimates are provided by Florida CHARTS as of 06/03/2014.

Ten Year Trend of AIDS Cases and Rates by Year of Report

AIDS cases increased in 2004 due to increased CD4 testing statewide. Additionally, enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. There was another surge in the expansion of ELR in 2012, which was subsequently followed by another increase in newly reported cases of AIDS in 2013. (Figure 4).

Figure 4. AIDS Cases and Rates,* by Year of Report, 2004-2013, Florida



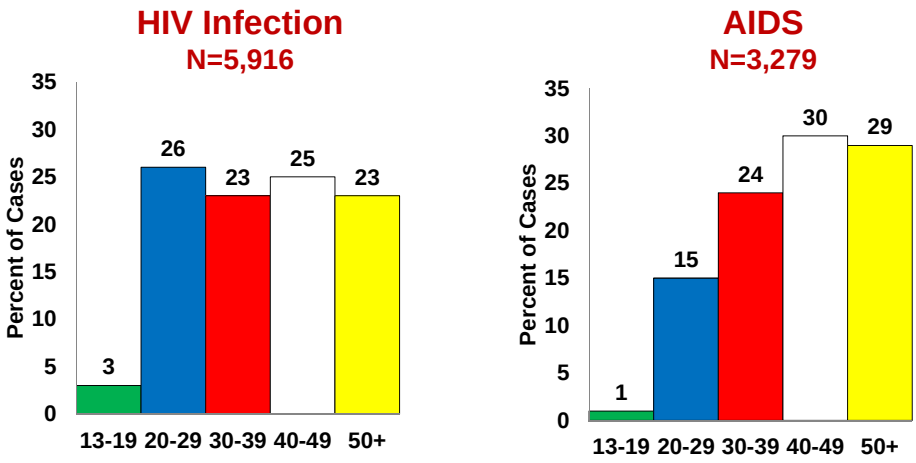
Year	Rate
04	30.6
05	25.9
06	26.5
07	19.8
08	24.8
09	21.6
10	16.9
11	17.4
12	13.9
13	17.0

*Source: Population estimates are provided by Florida CHARTS as of 06/03/2014.

Adult HIV Infection and AIDS Cases by Age

HIV infection cases tend to be younger than AIDS cases. A greater proportion of HIV infection cases reported in 2013 were among those aged 20-29 (26%), followed by those aged 40-49 (25%) (Figure 5). Conversely, the greatest proportion of AIDS cases reported in 2013 were among persons aged 40-49 (30%), followed by those in the 50 and older age group (29%) and those in the 30-39 age group (24%). Adult cases for both HIV and AIDS are defined as those occurring in people 13 years of age and older. The analysis shown below includes only adult cases.

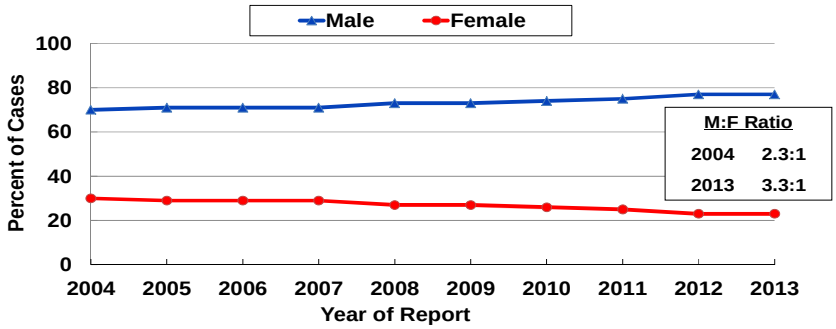
Figure 5. Age Distribution of Florida's Adult HIV Infection Cases Compared with the Age Distribution of Florida's Adult AIDS Cases, Reported in 2013, Florida



Ten Year Trend of Adult HIV Cases by Gender

In 2013, 77% of the adult HIV infection cases were male, compared to 70% in 2004 (Figure 6). Over the past ten years, the proportion of HIV infection cases among men has increased while the proportion among women has decreased. The result is an increase in the male-to-female ratio, from 2.3:1 in 2004 to 3.3:1 in 2013. The relative increase in male HIV cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM).

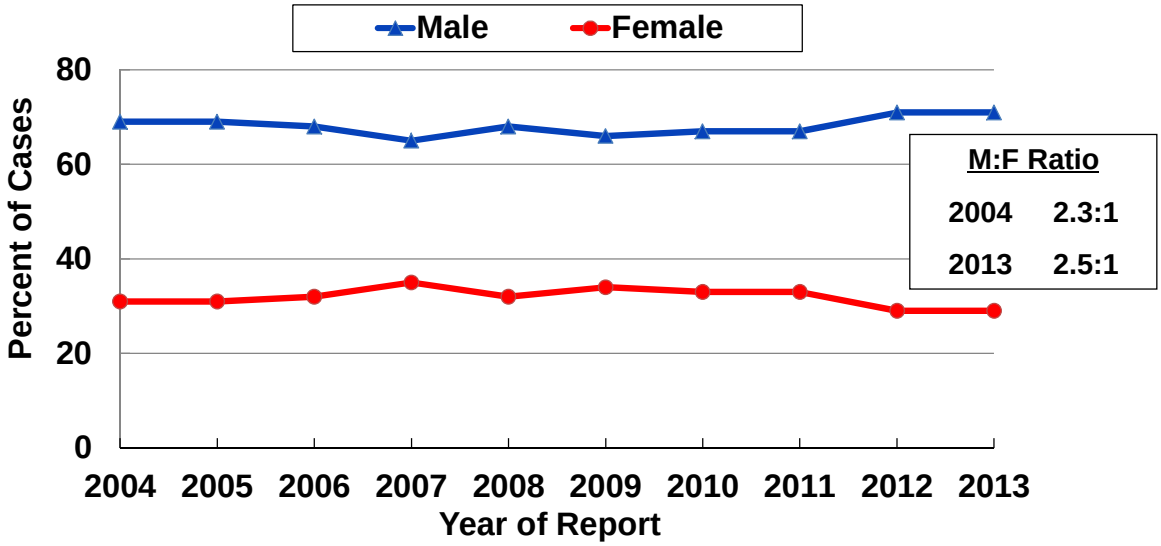
Figure 6. Percent of Adult HIV Infection Cases, by Gender and Year of Report, 2004-2013, Florida



Ten Year Trend of Adult AIDS Cases by Gender

Although the proportion of adult AIDS cases among men and women has remained fairly level, the proportion of male AIDS cases increased from 69% in 2004 to 71% in 2013 (Figure 7). As the proportion of males increase, the ratio of males-to-females increases as well, thus the male-to-female ratio increased slightly from 2.3:1 in 2004 to 2.5:1 in 2013.

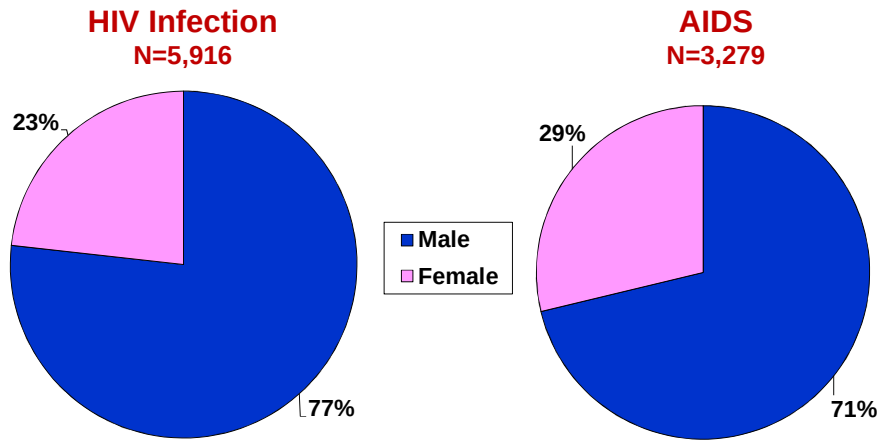
Figure 7. Percent of Adult AIDS Cases by Gender and Year of Report, 2004-2013, Florida



Adult HIV Infection and AIDS Cases by Gender

In 2013, a total of 4,542 adult males and 1,374 adult females were reported with HIV infection, representing 77% and 23% of cases, respectively (Figure 8). Also, in 2013 a total of 2,336 adult males and 943 adult females were reported with AIDS, representing 71% and 29% of cases, respectively.

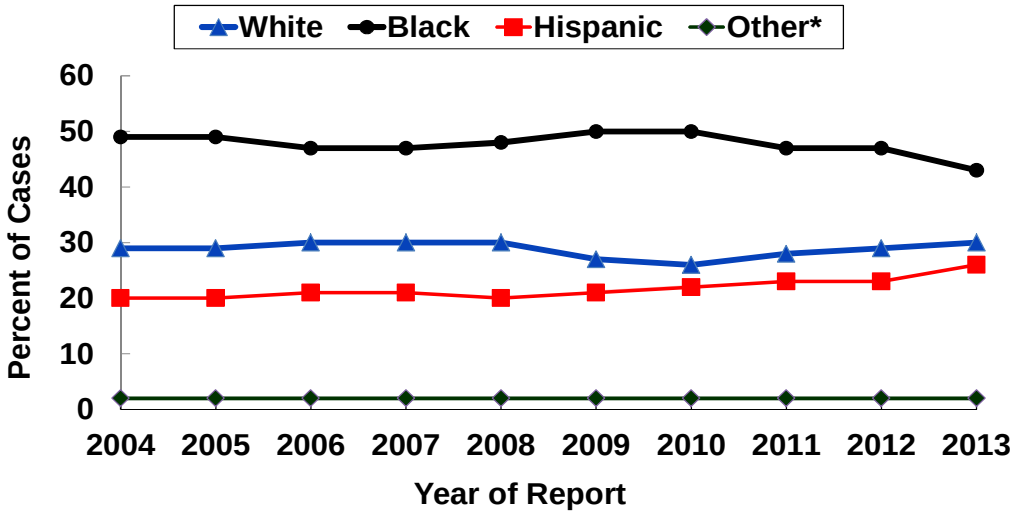
Figure 8. Percent of Adult HIV Infection and AIDS Cases by Gender, Reported in 2013, Florida



Ten Year Trend of Adult HIV Infection Cases by Race/Ethnicity

From 2004 to 2013, the proportion of adult HIV cases decreased by 6 percentage points among blacks (Figure 9). In contrast, increases were observed among both white (1 percentage point) and Hispanic (6 percentage points) HIV infection cases over this same time period.

Figure 9. Percent of Adult HIV Infection Cases, by Race/Ethnicity and Year of Report, 2004–2013, Florida

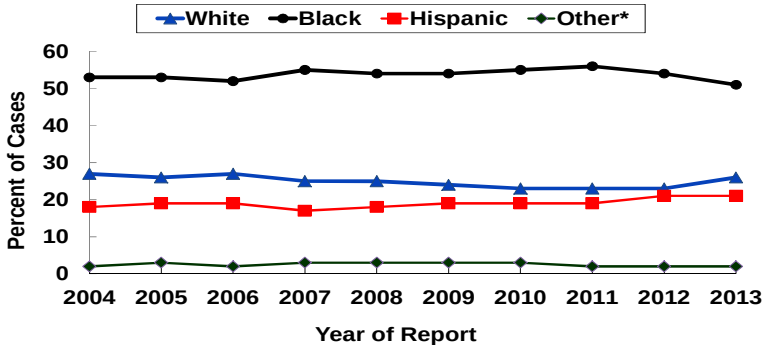


*Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.

Ten Year Trend of Adult AIDS Cases by Race/Ethnicity

Of the adult AIDS cases reported in 2013, 26% were white, compared to 51% black and 21% Hispanic (Figure 10). Over the past ten years, the proportion of AIDS cases has remained fairly level among all race/ethnic groups. However, during the same time period, blacks account for over 50% of reported AIDS cases each year.

Figure 10. Percent of Adult AIDS Cases, by Race/Ethnicity and Year of Report, 2004–2013, Florida

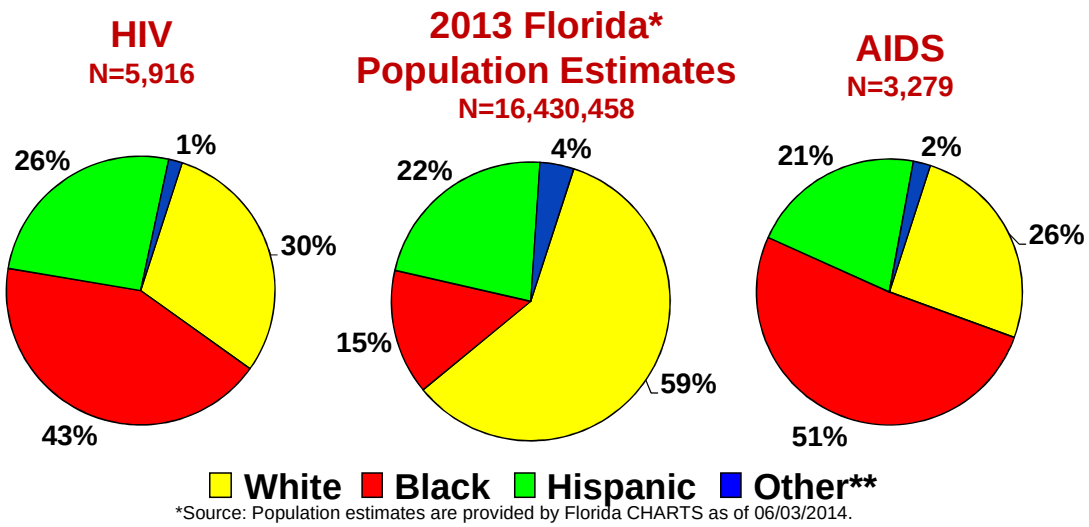


*Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.

Adult HIV Infection Cases, AIDS Cases, and Population Data by Race/Ethnicity

Blacks comprise only 15% of the adult population in Florida, but represent 43% of adult HIV infection cases and 51% of adult AIDS cases reported in 2013 (Figure 11). Hispanics comprise 22% of Florida's adult population, and account for 26% of the HIV infection cases and 21% of the AIDS cases.

Figure 11. Adult HIV Infection Cases, AIDS Cases and Population Data, by Race/Ethnicity, Reported in 2013, Florida



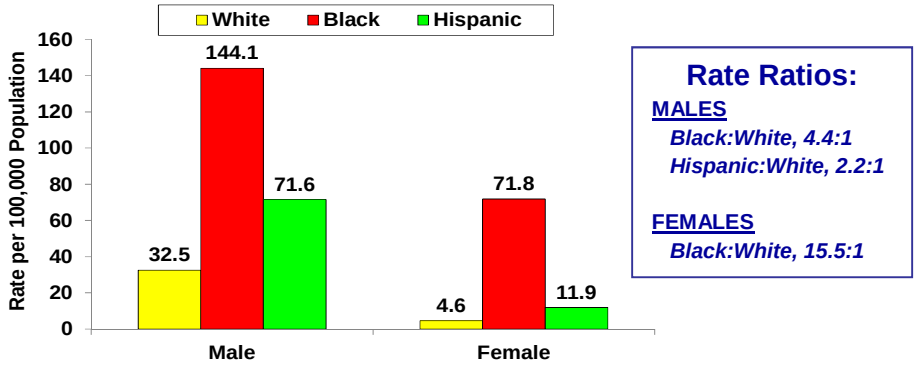
*Source: Population estimates are provided by Florida CHARTS as of 06/03/2014.

**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.

Adult HIV Infection Case Rates by Gender and Race/Ethnicity

Black men and, to an even greater extent, black women are over-represented in the HIV epidemic (Figure 12). The HIV case rate for 2013 is four times higher among black men than among white men. Among black women, the HIV case rate is nearly 16-fold greater than among white women. Hispanic male and Hispanic female HIV case rates are twice as high as the rates among their white counterparts.

Figure 12. Adult HIV Infection Case Rates* by Gender and Race/Ethnicity, Reported in 2013, Florida

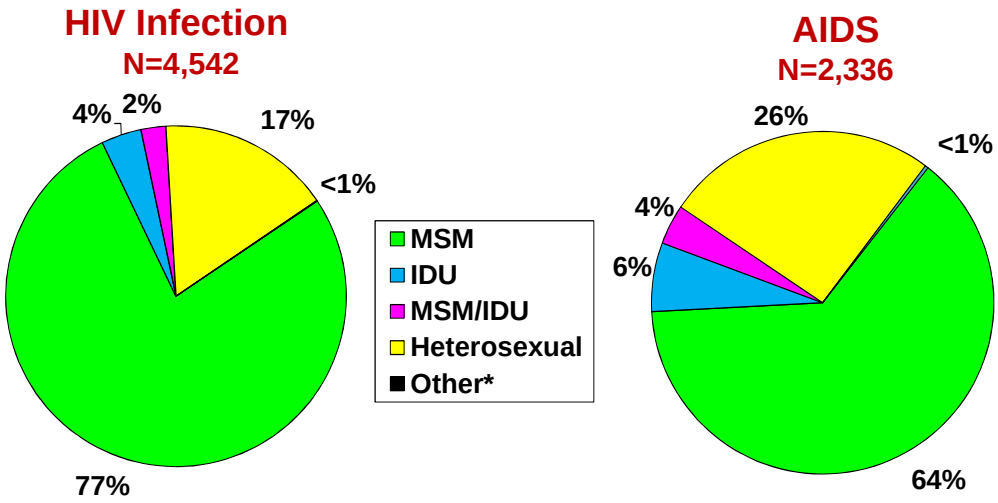


*Source: Population estimates are provided by Florida CHARTS as of 06/03/2014.

Adult Male HIV Infection and AIDS Cases by Mode of Exposure

Among the male HIV infection and AIDS cases reported for 2013, men who have sex with men (MSM) was the most common risk factor (77% and 64% respectively) followed by cases with a heterosexual risk (17% for HIV and 26% for AIDS) (Figure 13). HIV cases tend to represent a more recent picture of the epidemic.

Figure 13. Adult Male HIV Infection and AIDS Cases by Mode of Exposure, Reported in 2013, Florida

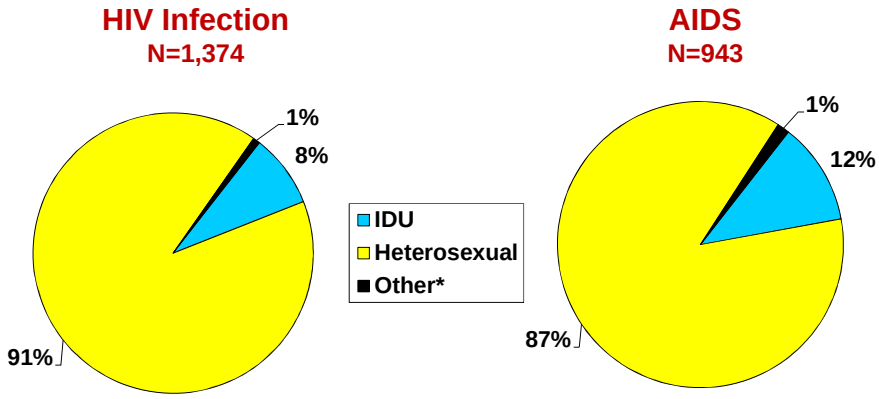


*Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks

Adult Female HIV Infection and AIDS Cases by Mode of Exposure

Among the female HIV infection and AIDS cases reported for 2013, heterosexual sex was the highest risk (91% and 87% respectively) (Figure 14).

Figure 14. Adult Female HIV Infection and AIDS Cases by Mode of Exposure, Reported in 2013, Florida



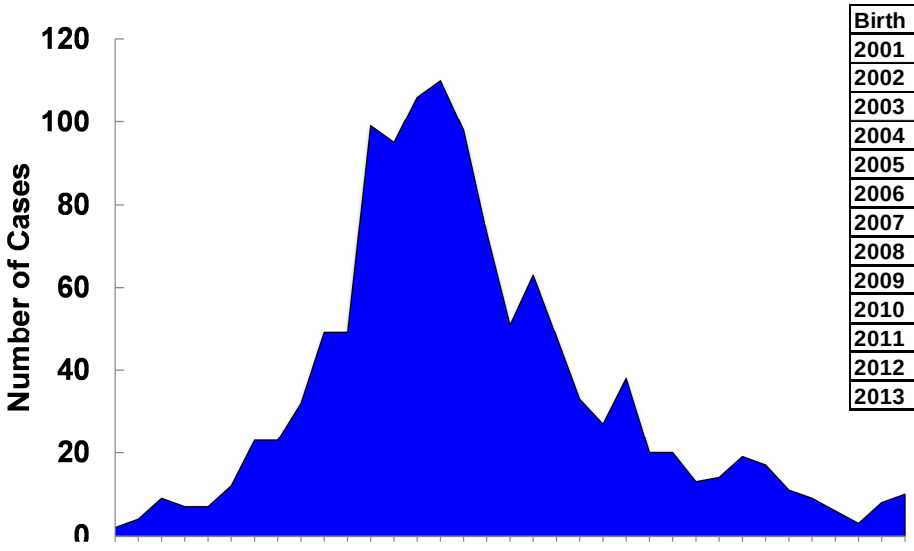
*Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks

Perinatal HIV/AIDS Cases

Of the 1,208 perinatally infected babies born in Florida from 1979 through 2013, two were born as early as 1979 (Figure 15). The birth of HIV-infected babies continued to rise through 1993. In April 1994, the U.S. Public Health Service released guidelines for zidovudine (ZDV) also known as azidothymidine (AZT), used to reduce perinatal HIV transmission, and in 1995 recommendations for HIV counseling and voluntary testing for pregnant women were published. Florida law, beginning in October 1996, required the offering of HIV testing to pregnant women. As a result of this increase in testing for HIV infection, more HIV-positive women could be offered ZDV during their pregnancy. Enhanced perinatal surveillance systems have documented increased use of ZDV among exposed infants and HIV-infected mothers at the prenatal, intrapartum, delivery and neonatal stages.

Prevention of perinatal HIV remains a very high priority in Florida. In the past few years, the use of other medical therapies, including protease inhibitors, has supplemented the use of ZDV for both infected mothers and their babies. The use of these medical therapies has been accompanied by a decrease in the number of perinatally HIV-infected infants and is responsible for the dramatic decline in perinatally acquired HIV/AIDS since 1994. Furthermore, numerous initiatives have contributed to the reduction in these cases. Major initiatives include: seven Targeted Outreach to Pregnant Women Act (TOPWA) programs, three perinatal nurses located in the most heavily impacted counties, social marketing and provider education. These initiatives have helped to further educate local providers on the importance of testing pregnant women for HIV and then offering effective treatment during the pregnancy and at delivery to further decrease the chances of vertical transmission. The use of these medical therapies has been followed by a decrease in the number of perinatally HIV-infected children and a dramatic decline in perinatally-acquired HIV/AIDS cases since 1994. There was a sharp decrease in 1993 with a leveling trend from 2002 to 2007, followed by another sharp decrease. In summary, these successful initiatives have resulted in a 91% decline perinatally infected births in Florida from 1993 (N=110) to 2013 (N=10).

Figure 15. Perinatally Acquired HIV Infected Cases, Born in Florida, by Year of Birth, 1979-2013 (N=1,208)



Birth	#	% change
2001	38	
2002	20	-47%
2003	20	0%
2004	13	-35%
2005	14	8%
2006	19	36%
2007	17	-11%
2008	11	-35%
2009	9	-18%
2010	6	-33%
2011	3	-50%
2012	8	167%
2013	10	25%

Prevalence Estimate of HIV Disease in the U.S. and Florida

Assessment of the extent of the HIV epidemic is an important step in community planning for HIV prevention and HIV/AIDS patient care. The HIV prevalence estimate, the estimated number of persons living with HIV infection, includes those living with a diagnosis of HIV or AIDS and those who may be infected but are unaware of their serostatus. According to recent estimates published by CDC, more than 1.1 million people are currently living with HIV infection in the U.S.[2] Florida has consistently reported 10-12% of the national AIDS morbidity and currently accounts for 11% of all persons living with AIDS in the U.S. The Florida Department of Health now estimates that at least 126,000 persons, or roughly 11% of the national total, are currently living with HIV infection in Florida as of the end of 2013.

There are some small differences and a few substantive differences between the proportional distributions of populations living with HIV infection in Florida as compared to the U.S. as a whole as noted in the table below (Table 3). Florida has a larger proportion of women (29%) compared to the U.S. (25%). By race/ethnicity, Florida has a larger proportion of blacks (48%) compared to the U.S. (44%). By mode of exposure, Florida has a smaller proportion of MSM (47% vs. 50%) and IDU (9% vs. 16%). However, Florida has a larger proportion of cases with heterosexual contact (38% vs. 26%). By age group the U.S. has a larger proportion of persons living with HIV infection older than the age of 50 (44% vs. 35%).

Table 3. Persons Living with HIV Disease by Selected Demographics and Risk Factors in the U.S. (2010)* and Florida (2013)**

Subgroup	U.S. (N=872,990)	Florida (N=98,530)
Male	75%	71%
Female	25%	29%
White	34%	29%
Black	44%	48%
Hispanic	19%	21%
Other	3%	2%
MSM	50%	47%
IDU	16%	9%
MSM/IDU	6%	4%
Heterosexual	26%	38%
Other	2%	2%
Age 0-24	5%	4%
Age 25-49	60%	52%
Age 50+	35%	44%

* Source: U.S. Data: CDC, HIV Surveillance Report, 2011, Vol. 23, Table 15a, estimated for 50 states with confidential name-based HIV infection reporting. Living data through 2010 is most recent available. **Florida Data: FL Department of Health, HIV/AIDS Section, eHARS, alive and reported through 2013, as of 06/30/2014.

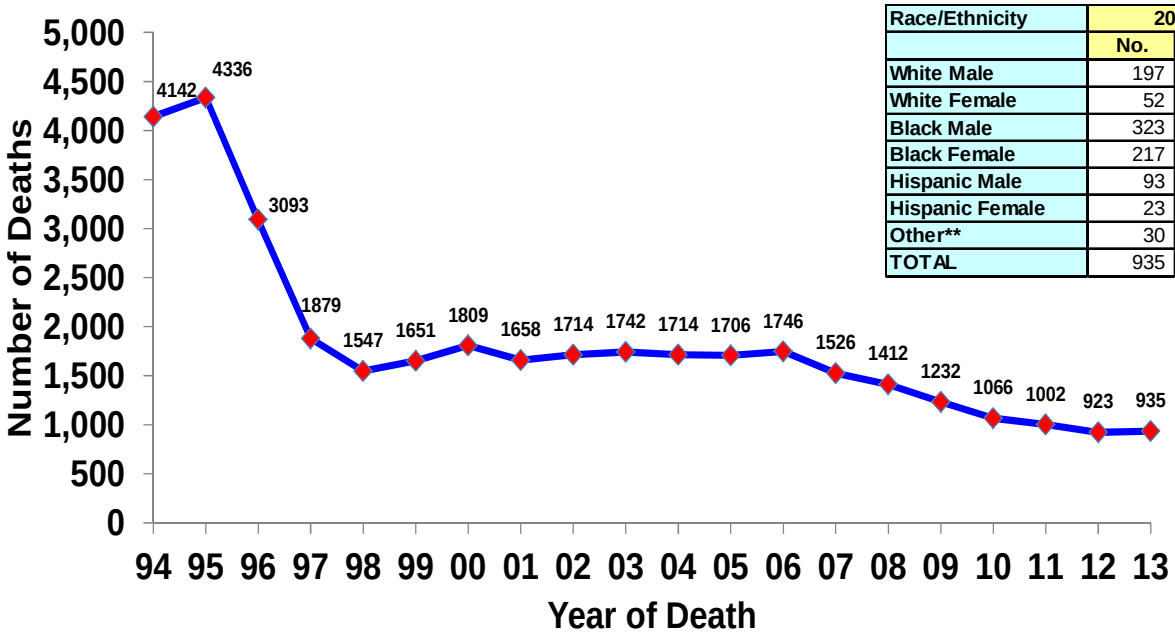
Impact of HIV-Related Deaths

HIV/AIDS deaths decreased markedly from 1996-1998 after the advent of highly active anti-retroviral therapy (HAART) in 1996. A leveling of the trend since 1998 may reflect factors such as viral resistance, late diagnosis of HIV, adherence problems, and lack of access to or acceptance of care (Figure 16). Overall, there has been a 78% decline in the number of Florida resident deaths due to HIV disease from 1995 (the peak of resident HIV-related deaths) to 2013. Since 2007, deaths have maintained a downward trend and may be starting to level off.

According to the Florida Bureau of Vital Statistics, for persons 25-44 years of age, in 2013 HIV was the:

- 6th leading cause of death.
- 5th leading cause of death among blacks (down from 4th in 2012).
- 8th leading cause of death among whites (up from 9th in 2012).
- 8th leading cause of death among Hispanics.
- 6th leading cause of death among men and the 5th leading cause of death among women.

Figure 16. Resident Deaths due to HIV Disease, by Year of Death, 1994–2013, Florida



Race/Ethnicity	2013	
	No.	rate*
White Male	197	3.7
White Female	52	0.9
Black Male	323	22.5
Black Female	217	14.0
Hispanic Male	93	4.1
Hispanic Female	23	1.0
Other**	30	3.6
TOTAL	935	4.8

*Source: Florida Department of Health, Office of Vital Statistics, Death Certificates (as of 05/16/2014). Population data are provided by Florida CHARTS 06/03/2014.

**Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.

Prioritization of Populations

A priority population is a group that is disproportionately impacted by HIV/AIDS. Priority populations are identified through the use of HIV/AIDS surveillance data and the community services assessment. These groups are found to be the groups that require intensive HIV prevention efforts due to high rates of HIV infection and high incidence of risky behaviors. Individuals within these populations may come from various socioeconomic and demographic backgrounds and engage in behaviors that place them at risk for HIV infection.

The PPG uses a method called the Three-Fold Path methodology to determine priority populations. The priority setting methodology was designed and implemented by the PPG to ensure that the selection of priority populations and the allocation of resources were fair and uniform across the state. Guidelines were formulated by the PPG Methodology Workgroup to assist partnerships in assessing local priority populations and assessing local community needs for HIV prevention interventions and activities.

Path 1: HIV Case Data (40% of Weight)
Rationale: Priority should be given to those populations where HIV infection is occurring. The CDC requires priority setting to be "data driven." HIV case data is a stronger indicator of where new infections are occurring than AIDS case data. At this point, HIV case reporting has been in place for over10 years.

Path 2: People living with HIV/AIDS in an area (40% of Weight)

Rationale: Priority should be given to those populations living with HIV/AIDS in an area. This methodology relies on people living with HIV/AIDS in an area to assist in prioritizing populations. The greater the impact of HIV on a particular population, the larger priority it will become. As the impact of HIV on a population decreases, the population will move lower on the priority list.

Path 3: Planning Partnership Deliberation (20% Weight)

Rationale: Planning Partnerships consist of people "in the field"—prevention specialists, health planners, community members, behavioral scientists, epidemiologists, and others invested in making a discernible difference in this disease. Their expertise should be utilized in setting priorities.

Each of the priority populations were ranked by placing them in numerical order of HIV case rank, cases of people living with HIV/AIDS, and PPG's deliberations. The numerical total of the three group rankings by priority population was totaled. The population with the lowest ranking total was the highest priority; the next lowest total was the second highest priority, etc. This methodology was followed at the local and state level.

The calculation of the final ranking is done in the following manner. Forty percent of the final ranking is based on HIV case data, 40% is based on people living with HIV/AIDS in an area, and 20% is based on the summed rankings of the fourteen prevention partnerships divided by fourteen.

THREE FOLD PATH METHODOLOGY and Advancing HIV Prevention (AHP) Tool					
	40% of weight	40% of weight	20% of weight	Sum of each	FINAL
	HIV Case	Living Cases	Combined	rank	RANK
Populations	Data Rank	Data Rank	Rank	weighted	
B-Hetero	1	1	1	3	1
B-IDU	8	6	7	21	7
B-MSM	3	4	4	11	4
H-Hetero	5	5	5	15	5
H-IDU	9	9	9	27	9
H-MSM	4	3	3	10	3
W-Hetero	6	7	6	19	6
W-IDU	7	8	8	23	8
W-MSM	2	2	2	6	2

Florida's Top 9 Priority Populations In 2013

Florida's Top-9 Priority Populations in 2013 for Primary and Secondary HIV Prevention Based on Persons Living with HIV Disease

1. Black Heterosexual men and women
2. White Men who have sex with Men
3. Hispanic Men who have sex with Men
4. Black Men who have sex with Men
5. Hispanic Heterosexual men and women
6. White Heterosexual men and women
7. Black Injection Drug User
8. White Injection Drug User
9. Hispanic Injection Drug User

This final ranking is a result of ranking 9 race/risk groups among those newly reported in eHARS with HIV disease in Florida from the 3 most recent years, plus ranking these same 9 race/risk groups from all persons who were reported and living with HIV disease in eHARS in Florida through the most recent calendar year. The two ranks were then weighted and combined resulting in the final rank.

Assessment of Need

The community assessment serves as the basis for identifying populations at risk for HIV infection in Florida, the prevention needs of those populations, activities/interventions being implemented to address those needs and service gaps. To help assess current needs for HIV prevention services in Florida, the PPG in collaboration with the prevention program conducted an HIV Provider Survey in July 2014. The HIV Provider survey was conducted as part of an ongoing needs assessment process to identify needs and service gaps related to the delivery of HIV services in Florida. The results of the survey are used to help the Prevention Program better understand the prevention need for persons living with HIV/AIDS and those at risk for HIV.

The survey was open from July 30, 2014-September 30, 2014. Survey responses were collected electronically utilizing Survey Monkey. In total there were 397 survey respondents. The survey consisted of 33 questions designed to gather information from providers about the types of HIV services provided statewide, access to services, coordination of HIV services, barriers to HIV services and HIV service needs. Survey responses were summarized through Survey Monkey and subsequently reviewed by the PPG and Prevention Program staff.

Analysis of data from the provider survey produced the following key findings related to barriers to HIV/AIDS services, unmet need, and technical assistance and training needs:

Barriers to HIV/AIDS Services

- Survey respondents identified the following as the top three barriers that their organization faces when providing services to people living with HIV/AIDS or those at risk for acquiring HIV. The top three responses were: 1) inadequate funding resources (n=72); 2) stigma, mainly related to HIV status (n=44); and 3) inadequate transportation (n=32).

- When respondents were asked to identify the top three barriers that their organization faces when trying to find people who are unaware of their HIV status the following barriers were identified: 1) stigma, mainly related to HIV status (n=66); 2) clients not ready to receive HIV test results/address health care (n=33); and 3) mistrust of the medical system/providers (n=26).

- The top three barriers that were identified as barriers for organizations linking and retaining HIV-positive individuals were: 1) clients are afraid to disclose HIV status (n=48); 2) clients not ready to address health care (n=34); and 3) transportation (n=29).

- Respondents were asked to identity what they felt were the most common barriers that clients face when accessing services. Respondents were given a selection of common barriers to select from. The top three barriers that providers strongly agreed with were: 1) our clients are reluctant to seek services due to stigma and/or fear of disclosing HIV

status (n=71); 2) our clients have difficulties getting transportation to our organization (n=59); and 3) our clients are unsure of how to navigate the care system (n=51).

Unmet Need

- Respondents were asked to identify the three most important unmet needs for HIV prevention in their area. The top three identified unmet needs were: 1) mental health services (n=35); 2) substance abuse services (n=22); and 3) peer programs (n=21).

Technical Assistance and Training Needs

- Survey respondents were asked to identify training topics or technical assistance areas that would help them to better serve clients. The top three responses for training and technical assistance were: 1) recruiting hard-to-reach populations (n=116); 2) linkage to and retention in care (n=112); and 3) mental health (n=95).

Section 1: Respondent Demographics

Gender (n=395 respondents)

Female……263 (67%)
Male……127 (32%)
Transgender Male……3 (.8%)
Transgender Female……2 (.5%)

Race (n=386 respondents)

White……239 (62%)
Black……138 (36%)
Asian……5 (1%)
American Indian or Alaskan Native……14 (4%)
Native Hawaiian or Pacific Islander……1 (.3%)
Other……9 (2.3%)
Multiracial (3) Haitian (3) Hispanic/Latino (2) Neither (1)

Hispanic or Latino Descent (n=388 respondents)

Yes……53 (14%)
No……335 (86%)

Describe your primary role within your agency. (n=344 respondents)

Physician……12 (4%)
Physician Assistant……0 (0%)
Nurse Practitioner……12 (4%)
Nurse……36 (11%)
Psychologist……1 (.3%)
Social Worker……11 (3%)
Substance Abuse Professional……2 (.6%)
Health Educator……50 (15%)
Counselor……10 (3%)
Case Manager……33 (10%)
Outreach Worker……14 (4%)
Peer Navigator/Educator……13 (4%)
Prevention Specialist……18 (5%)
Executive Director/Administrator……25 (7%)
Program Coordinator/Manager……85 (25%)
Receptionist/Secretary……6 (2%)
Advocate……10 (3%)
Board Member……6 (2%)

How long have you worked at your agency? (n=391 respondents)

Less than 1 year……36 (9%)
1 to 4 years……99 (25%)
More than 4, but less than 10 years……110 (28%)
10 years or more……146 (37%)

Do you currently provide direct medical care? (n=397 respondents)

Yes……102 (26%)
No……287 (72%)
Unsure……8 (2%)

Do you currently provide HIV prevention services? (n=397 respondents)	If answered yes to the previous question, do you consider yourself to be an HIV specialist? (n=305 respondents)
Yes……317 (79%) No……70 (18%) Unsure……13 (3%)	Yes…… 81(27%) No……..67 (22%) Not Applicable……...157 (52%)

Section 2: Agency Characteristics

Total Number of Agencies Responding to the Survey
(n=341 respondents)

Which of the following best describes your agency?
(n=316 respondents)

Community-based organization (not AIDS specific)……47 (15%)
Faith-based organization……14 (4%)
Mental health treatment provider……2 (.6%)
Substance abuse treatment provider……11 (4%)
Multi-service agency with HIV/AIDS services……34 (11%)
Physician/private doctor……0 (0%)
Hospital……9 (3%)
Health clinic……23 (7%)
HIV/AIDS clinic……39 (12%)
County health department clinic……137 (43%)
Other (please specify)…… ...47(.4%)

Is your agency currently a federally qualified health center?
(n=341 respondents)

Yes……92 (27%)
No……180 (53%)
Look-alike……3 (.9%)
Unsure……66 (19%)

Does your agency currently target services to people living with HIV/AIDS?
(n=339 respondents)

Yes……306 (90%)
No……33 (10%)

Does your agency currently target services to people at risk of acquiring HIV?
(n=342 respondents)

Yes……313 (92%)
No……29 (9%)

Please select the area in which your agency provides services.
(n= 299 respondents)

Area 1……32 (11%)
Area 2A……21 (7%)
Area 2B……32 (11%)
Area 3/13……35 (12%)
Area 4……67 (22%)
Area 5……28 (9%)
Area 6……28 (9%)
Area 7……15 (5%)
Area 8……42 (14%)
Area 9……21 (7%)
Area 10……18 (6%)
Area 11A……22 (7%)
Area 11B……18 (6%)
Area 12……17 (6%)
Area 14……14 (5%)
Area 15……9 (3%)

Section 3: Target Populations Served

Please select the population(s) that represents the majority of your current clients. (n= 344 respondents)

	Male	Female	Transgender Male to Female	Transgender Female to Male	Total Response Count
White/Caucasian	248	193	79	38	274
Black/African-American/African-Caribbean	284	265	76	41	306
Hispanic/Latino	185	169	47	29	196
Asian	51	48	20	17	59
American Indian or Alaskan Native	29	25	13	10	31
Native Hawaiian or Pacific Islander	26	22	11	8	27
Other (please specify)					22

Please select the age(s) of the populations served by your agency. (n=314 respondents)

All Ages……146 (43%)
Under 13 Years Old……23 (7%)
13-18 Years Old……100 (29%)
19-24 Years Old……181 (33%)
25-44 Years Old……176 (52%)
45-64 Years Old……171 (50%)
65 and older……144 (42%)

Please select any special sub-populations currently served by your agency. (n=327)

Homeless……253 (77%)
Immigrants (documented and undocumented)……207 (63%)
Incarcerated/Formerly Incarcerated……223 (68%)
People with Disabilities……197 (60%)
People with Mental Health Illness……238 (73%)
Sex Industry Workers……176 (54%)
Domestic Violence Survivors……159 (49%)
Substance User……250 (77%)
Youth……192 (59%)
Men who have Sex with Men (MSM)……289 (88%)
Co-occurring Mental Health and Substance Abuse……214 (65%)
Injection Drug Users……196 (60%)
Hepatitis Clients……198 (61%)

Co-Morbidity Clients (2 or more infections)……191 (58%) Other (please specify)……15(4.6%)

Section 4: Agency Funding and Services Provided

Is your agency currently funded to provide HIV prevention services? (n=340)	**How many years have your agency provided HIV prevention services? (n=293)**
Yes……267 (79%) No……...37 (11%) Unsure……...36 (11%)	Less than 1 year……1 (0.3%) 1 to 4 years……19 (7%) 5 to 9 years……21 (7%) 10 to 15 years……38 (13%) 16 to 20 years……45 (15%) 20 years or more……169 (58%)

Please indicate your current funding sources for HIV prevention services. (n=298)

Centers for Disease Control and Prevention (CDC) direct funding……86 (29%)
Florida Department of Health (DOH)……244 (82%)
Private grant funds/ foundations……57 (19%)
City or county funding……61 (21%)
Health Resources and Service Administration (HRSA)/Ryan White……131 (44%)
Private donations……35 (12%)
Substance Abuse and Mental Health Services Administration (SAMHSA)……38 (13%)
Florida Department of Children and Families (DCF)……23 (8%)
Other (please specify if not applicable)……26 (8.7%)

Does your agency currently (within the past year) offer any of the following services? (n=301)

HIV counseling and testing services……282 (94%)
Clinic-based HIV treatment education and adherence……180 (60%)
Community-based HIV treatment education……178 (59%)
Clinic-based medical case management for People Living with HIV/AIDS (PLWHA)…155 (52%)
Primary HIV medical care……154 (51%)
Community-based medical case management for People Living with HIV/AIDS (PLWHA)……113 (38%)
Community-based case management for persons at risk for HIV……92 (31%)
Non-medical case management for People Living with HIV/AIDS (PLWHA)……123 (41%)
Peer programs……126 (42%)
Support group for People Living with HIV/AIDS (PLWHA)……118 (39%)
Behavioral interventions for People Living with HIV/AIDS (PLWHA)……120 (40%)
Behavioral interventions for persons at risk for HIV……117 (39%)
HIV partner services……143 (48%)

Screening/assessment for HIV and other Sexually Transmitted Infection (STI) risk……211 (70%)
Sexually Transmitted Infection (STI) testing……204 (68%)
Condom distribution……265 (88%)
Substance abuse services……68 (23%)
Mental health services……130 (43%)
Health education and risk reduction……238 (79%)
Social marketing/community mobilization……104 (35%)
Family planning services……134 (45%)
Domestic violence services……49 (16%)
Field outreach……185 (62%)
Information and referral services……200 (66%)
Other social or support services……149 (50%)
Other health-related services……126 (42%)
Hepatitis services……125 (42%)
Other (please specify)……20 (6.7%)

Section 5: Provider Knowledge, Beliefs, and Practices

For each statement, please answer accordingly. (n=301)							
	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**	**Response Count**
As a provider, I have a clear understanding of high-impact prevention.	146 (49%)	105 (35%)	22 (7%)	7 (2%)	3 (1%)	17 (5%)	300
As a provider, I have a clear understanding of targeted HIV testing for HIV prevention and care efforts.	169 (56%)	95 (32%)	14 (5%)	3 (1%)	1 (.3%)	18 (6%)	300
As a provider, I have a clear understanding of pre-exposure prophylaxis (PrEP) for HIV prevention.	124 (42%)	105 (36%)	32 (11%)	10 (3%)	1 (.3%)	21 (7%)	293
As a provider, I have a clear understanding of post-exposure prophylaxis (PEP) for HIV prevention.	122 (41%)	113 (38%)	30 (10%)	8 (3%)	2 (.7%)	22 (7%)	297
As a provider, I have a clear understanding of the use of anti-retroviral therapy for HIV prevention.	147 (49%)	97 (32%)	27 (9%)	6 (2%)	2 (.7%)	20 (7%)	299
As a provider, I have a clear understanding of prevention for positives services.	152 (51%)	92 (31%)	28 (9%)	5 (2%)	1 (.3%)	19 (6%)	297
As a provider, I have a clear understanding of how to incorporate prevention for positives services into my organization/work.	148 (50%)	94 (32%)	30 (10%)	5 (2%)	1 (.3%)	20 (7%)	298
As a provider, I have a clear understanding of condom distribution programs.	184 (62%)	81 (27%)	11 (4%)	1 (.3%)	2 (.7%)	18 (6%)	297
As a provider, I am comfortable providing linkage to care and treatment.	185 (62%)	79 (27%)	13 (4%)	0 (0%)	1 (.3%)	1 (6%)	297

As a provider, I am comfortable educating persons at the time of their HIV diagnosis about the benefits of HIV medical care for improving personal health.	183 (62%)	75 (25%)	15 (5%)	2 (.7%)	1 (.3%)	21 (7%)	297
As a provider, I am comfortable educating persons at the time of their HIV diagnosis about preventing HIV transmission.	184 (62%)	83 (28%)	10 (3%)	2 (.7%)	1 (.3%)	19 (6%)	299
As a provider, I am comfortable providing interventions to improve retention in and re-engagement to care	153 (51%)	95 (32%)	21 (7%)	4 (1%)	1 (.3%)	24 (8%)	298
As a provider, I feel comfortable offering referral services to HIV testing providers, community-based HIV prevention providers, HIV care providers, case managers, and health departments.	177 (59%)	92 (31%)	9 (3%)	1 (.3%)	1 (.3%)	18 (6%)	298
As a provider, I feel comfortable discussing risky behaviors (unprotected sex, multiple sex partners, same-sex sexual behaviors, intravenous drug use, etc.) with my clients.	199 (67%)	72 (24%)	9 (3%)	1 (.3%)	1 (.3%)	17 (6%)	299
As a provider, I have an important role in educating clients on risky behaviors and their consequences.	199 (67%)	73 (25%)	8 (3%)	0 (0%)	1 (.3%)	17 (6%)	298
As a provider, I am comfortable working with diverse populations.	206 (69%)	66 (22%)	7 (2%)	0 (0%)	1 (.3%)	17 (6%)	297
As a provider, I am comfortable providing services to diverse populations of men who have sex with men (MSM).	200 (67%)	71 (24%)	8 (3%)	0 (0%)	1 (.3%)	18 (6%)	298

Choose the response that best reflects current activities within your organization. (n=301)					
	None or almost none of the time	**About half of the time**	**All or almost all of the time**	**Not Applicable**	**Response Count**
About how often do you ask patients/clients if they are sexually active?	14 (5%)	25 (8%)	221 (74%)	40 (13%)	300
About how often do you talk about safer sex with patients/clients?	16 (5%)	27 (9%)	222 (74%)	35 (12%)	300
About how often do you ask patients/clients about sexual satisfaction?	108 (36%)	63 (21%)	66 (22%)	59 (20%)	296
About how often do you ask patients/clients about using injection drugs or sharing needles?	32 (11%)	48 (16%)	176 (59%)	41 (14%)	297
At staff meetings, we discuss efforts to address HIV risk and prevention among our patients/clients.	48 (16%)	66 (22%)	148 (50%)	35 (12%)	297

Choose the response that best corresponds to the degree to which you agree or disagree with the following statements. (n=292)							
Answer Options	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Not Applicable**	**Response Count**
Our clinic has written procedures for HIV prevention counseling with HIV-positive patients	18 (6%)	11 (4%)	27 (9%)	90 (31%)	99 (34%)	46 (16%)	291
Specialists trained in HIV prevention counseling are more appropriate for delivering HIV prevention services to HIV-positive patients/clients than are primary care providers.	18 (6%)	28 (10%)	61 (21%)	67 (23%)	99 (34%)	16 (6%)	289
Staff at our clinic routinely screens HIV-positive patients/clients to determine their current risk of transmitting HIV to others.	17 (6%)	12 (4%)	28 (10%)	82 (28%)	98 (34%)	53 (18%)	290
No matter how much you counsel some patients/clients with HIV, they are still going to infect others.	39 (14%)	65 (23%)	79 (27%)	63 (22%)	26 (9%)	16 (6%)	288
Information, fliers and pamphlets about HIV and HIV transmission are readily available at our organization.	20 (7%)	6 (2%)	8 (3%)	65 (22%)	179 (61%)	14 (5%)	292
Our organization has the resources to make referrals for HIV-positive patients/clients who cannot resolve personal barriers to reducing risk.	20 (7%)	15 (5%)	21 (7%)	91 (31%)	120 (42%)	22 (8%)	289

Section 6: Barriers to HIV/AIDS Services

What are the top three barriers that your organization faced when providing services to people living with or at risk for acquiring HIV/AIDS? (With one being the greatest barrier) (n=247)				
Answer Options	**One**	**Two**	**Three**	**Response Count**
Inadequate funding resources	72 (62%)	24 (21%)	20 (17%)	116
Lack of substance abuse and/or mental health facilities	18 (29%)	25 (40%)	19 (31%)	62
Stigma, mainly related to homosexuality	20 (38%)	24 (45%)	9 (17%)	53
Stigma, mainly related to HIV status	51 (42%)	44 (36%)	26 (21%)	121
Stigma, mainly related to illicit drug use	2 (14%)	4 (29%)	8 (57%)	14
Lack of affordable housing and/or shelter facilities	16 (23%)	25 (36%)	28 41%)	69
Inadequate transportation	28 (29%)	38 (39%)	32 (33%)	98
HIV messages are outdated/inappropriate for intended audiences	5 (18%)	9 (33%)	13 (48%)	27
Location of services (distance or accessibility)	9 (21%)	10 (23%)	24 (56%)	43
Mistrust of the medical system/providers	6 (16%)	14 (37%)	18 (47%)	38
Staff capacity	10 (25%)	15 (38%)	15 (38%)	40
Cultural and/or language barriers	6 (17%)	6 (17%)	23 (66%)	35

What are the top three barriers your organization faced when trying to find people with HIV/AIDS who are unaware of their status? (With one being the greatest barrier) (n=231)				
Answer Options	**One**	**Two**	**Three**	**Response Count**
Surrounding communities are unaware of services offered	25 (43%)	14 (24%)	19 (33%)	58
Poor communication tools	4 (21%)	6 (32%)	9 (16%)	19
Stigma, mainly related to homosexuality	25 (45%)	21 (38%)	9 (16%)	55
Stigma, mainly related to HIV status	66 (54%)	43 (35%)	14 (11%)	123
Stigma, mainly related to illicit drug use	3 (25%)	5 (42%)	4 (33%)	12
Clients not ready to receive HIV test results/address health care	44 (43%)	33 (32%)	25 (25%)	102
Clients disenfranchised from medical care system	13 (25%)	18 (35%)	20 (39%)	51
Inadequate referral system and/or resources	2 (15%)	4 (31%)	7 (54%)	13
Clients do not understand HIV testing	4 (24%)	6 (35%)	7 (41%)	17
HIV messages are outdated and/or inappropriate for intended audiences	0 (0%)	4 (22%)	14 (78%)	18
Limited resources for HIV testing	12 (46%)	8 (31%)	6 (23%)	26
Partner Services are underutilized	2 (12%)	4 (24%)	11 (65%)	17
Inadequate transportation	9 (21%)	19 (45%)	14 (33%)	42
Location of services (distance of accessibility)	8 (32%)	8 (32%)	9 (36%)	25
Mistrust of the medical system/providers	2 (5%)	14 (33%)	26 (62%)	42
Staff capacity	6 (21%)	12 (41%)	11 (38%)	29
Cultural and/or language barriers	4 (15%)	8 (30%)	15 (56%)	27

What are the top three barriers your organization faced in linking and retaining HIV-positive individuals in HIV medical care? (With one being the greatest barrier) (n=235)				
Answer Options	**One**	**Two**	**Three**	**Response Count**
Clients unaware of services offered	22 (42%)	7 (13%)	23 (44%)	52
Clients are afraid to disclose HIV status	48 (58%)	18 (22%)	17 (20%)	83
Stigma, mainly related to HIV status	36 (42%)	29 (34%)	20 (24%)	85
Stigma, mainly related to homophobia	3 (15%)	12 (60%)	5 (25%)	20
Stigma, mainly related to illicit drug use	2 (29%)	3 (43%)	2 (29%)	7
Clients not ready to address health care	40 (40%)	34 (34%)	25 (25%)	99
Cultural and/or language barriers	1 (5%)	12 (57%)	8 (38%)	21
Staff capacity	5 (28%)	9 (50%)	4 (22%)	18
Clients disenfranchised from medical care system	7 (23%)	10 (33%)	13 (43%)	30
Clients distrust the medical care system	4 (15%)	12 (46%)	10 (38%)	26
Substance abuse/mental health issues	28 (39%)	21 (30%)	22 (31%)	71
HIV messages are outdated and/or inappropriate for intended audiences	0 (0%)	1 (50%)	1 (50%)	2
Partner Services are underutilized	1 (33%)	1 (33%)	1 (33%)	3
Lack of understanding of benefits of medical care	11 (17%)	24 (36%)	31 (47%)	66
Location of services (distance and accessibility)	6 (24%)	11 (44%)	8 (32%)	25
Transportation	20 (28%)	22 (31%)	29 (41%)	71

Listed below are some common barriers that clients face when accessing services. Based on your experiences during the past year, please answer accordingly. (n=244)							
Answer Options	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**	**Response Count**
Our clients have difficulties keeping their appointments.	50 (21%)	101 (42%)	43 (18%)	28 (12%)	3 (1%)	15 (6%)	240
Our clients have difficulties getting transportation to our organization.	59 (25%)	87 (37%)	32 (13%)	35 (15%)	7 (3%)	18 (8%)	238
Our clients have difficulties accessing services due to the location of our organization.	17 (7%)	35 (15%)	53 (23%)	76 (33%)	31 (13%)	20 (9%)	232
Our clients have difficulties accessing services due to hours of our organization.	10 (4%)	29 (12%)	46 (20%)	92 (39%)	36 (15%)	21(9%)	234
Our clients have difficulties accessing services due to family and/or childcare needs.	15 (6%)	63 (27%)	62 (26%)	56 (24%)	21 (9%)	19 (8%)	236
Our clients have difficulties accessing services due to substance abuse issues.	35 (15%)	97 (41%)	53(22%)	29 (12%)	9 (4%)	14 (6%)	237
Our clients have difficulties accessing services due to mental health issues.	45 (19%)	95 (40%)	53 (22%)	25 (11%)	7 (3%)	13 (5%)	238
Our clients are reluctant to seek services due to financial barriers.	31 (13%)	76 (32%)	44 (19%)	54 (23%)	16 (7%)	13 (6%)	234
Our clients are unsure of how to navigate the care system.	51(21%)	99 (41%)	43 (18%)	27 (11%)	8 (3%)	12 (5%)	240
Our clients have difficulties remaining engaged in care because they do not understand the risk of waiting to get into care.	35 (15%)	100 (42%)	40 (17%)	42 (18%)	9 (4%)	13 (5%)	239
Our clients are reluctant to demand treatment services once diagnosed as HIV positive.	32 (14%)	62 (27%)	58 (25%)	57 (24%)	8 (3%)	16 (7%)	233

Our clients are reluctant to seek services due to stigma and/or fear of disclosing HIV status.	71 (30%)	95 (40%)	41 (17%)	19 (8%)	3 (1%)	10 (4%)	239
Our clients are reluctant to seek services due to homophobia.	25 (11%)	53 (23%)	55 (23%)	67 (29%)	19 (8%)	16 (7%)	235
Our clients do not seek services because HIV care and treatment is not a priority for them.	25 (11%)	93 (40%)	55 (23%)	43 (18%)	8 (3%)	11 (5%)	235
Our clients do not seek services because they are not aware of where to find services.	9 (4%)	51 (22%)	48 (20%)	93 (40%)	19 (8%)	15 (6%)	235
Our clients do not seek services because they are not ready to deal with their status.	49 (21%)	118 (50%)	38 (16%)	20 (8%)	1 (.4%)	11 (5%)	237
Our clients trust me as a provider.	79 (33%)	110 (46%)	22 (9%)	4 (2%)	1 (.4%)	22 (9%)	238

Section 7: Unmet Need of HIV Prevention Services

In your opinion, what are the three most important unmet needs for HIV prevention services in your area? (With one being the greatest unmet need) (n=236)				
Answer Options	**One**	**Two**	**Three**	**Response Count**
HIV counseling and testing services	15 (52%)	6 (21%)	8 (28%)	29
Clinic-based HIV treatment education and adherence	17 (74%)	5 (22%)	1 (4%)	23
Community-based HIV treatment education	12 (44%)	11 (41%)	4 (15%)	27
Clinic-based medical case management for PLWHA	4 (27%)	7 (7%)	4 (27%)	15
Community-based medical case management for PLWHA	5 (42%)	4 (33%)	3 (25%)	12
Community-based case management for persons at risk for HIV	5 (42%)	7 (33%)	9 (43%)	21
Primary HIV medical care	18 (43%)	16 (38%)	8 (19%)	42
Peer programs	18 (35%)	12 (24%)	21 (41%)	51
Support groups for PLWHA	9 (22%)	18 (44%)	14 (34%)	41
Behavioral interventions for PLWHA	9 (28%)	15 (47%)	8 (25%)	32
Behavioral interventions for persons at risk for HIV	9 (28%)	13 (41%)	10 (31%)	32
HIV partner services	7 (23%)	10 (32%)	14 (45%)	31
Screening/assessment for HIV transmission risk behaviors and sexually transmitted diseases	5 (36%)	3 (21%)	6 (43%)	14
STD testing	8 (53%)	5 (33%)	2 (67%)	15
Condom distribution	0 (0%)	1 (33%)	2 (67%)	3
Substance abuse services	16 (32%)	22 (44%)	12 (24%)	50
Mental health services	35 (47%)	21 (28%)	19 (25%)	75
Health education and risk reduction	4 (16%)	9 (36%)	12 (48%)	25
Social marketing/community mobilization	10 (33%)	9 (30%)	11 (37%)	30
Family planning services	2 (20%)	1 (10%)	7 (70%)	10
Domestic violence services	1 (11%)	6 (67%)	2 (22%)	9
Field outreach	6 (33%)	3 (17%)	9 (50%)	18
Online outreach	5 (19%)	13 (48%)	9 (33%)	27
Information and referral services	2 (20%)	4 (40%)	4 (40%)	10
Other social or support services	9 (26%)	7 (21%)	18 (53%)	34
Other health-related services	4 (24%)	2 (12%)	11 (65%)	17

Section 8: Technical Assistance and Training Needs

Which of the following training topics or technical assistance areas would help you to better serve clients living with or at risk of acquiring HIV/AIDS (n=237)

Linkage to and retention in care……112 (47%)
Behavioral risk screening……59 (25%)
Partner services……46 (19%)
ART for HIV prevention……64 (27%)
Adherence to ART……74 (31%)
STD services……52 (22%)
Reproductive health care……34 (14%)
Health literacy……78 (33%)
HIV and co-morbidities……72 (30%)
Peer navigation……65 (27%)
Cultural competency……60 (25%)
HIV testing and counseling……33 (14%)
HIV partner services……57 (24%)
Ryan White……43 (18%)
Substance abuse……86 (36%)
Mental health……95 (40%)
Behavioral interventions……89 (38%)
Social marketing……61 (26%)
Outreach……49 (21%)
Domestic violence……35 (15%)
Condom distribution……23 (10%)
Fiscal management……29 (12%)
Grant writing……66 (28%)
Outreach and recruitment……58 (25%)
Motivational interviewing……62 (26%)
Social networks……57 (24%)
Recruiting hard-to-reach populations……116 (50%)

Section 9: Suggested Strategies

What strategies have you used, or should be used, to successfully identify people with HIV/AIDS who are unaware of their status?
(n=210)
**Sample of responses provided*

- Partnering with CBOs to utilize social media
- We use our peers to help identify those in their social network
- Community mobilization and advocacy action
- Utilization of geographic data
- Testing in hospital emergency departments and using staff to liaison with the hospital to identify those newly diagnosed and linked to care
- Routine risk screening for all patients; offering HIV testing on site
- I have found being out in the population helps me. Passing out condoms and talking with a wide range of individuals (homosexual or heterosexual) points me in the right direction. You never know which one will spread the information I have given to them, causing another individual to come in and get tested.
- Community events that provide testing in high-risk areas. Incentives (gift cards) to encourage people to get tested. Education on HIV/AIDS and how it is transmitted.
- Partner testing for newly diagnosed persons
- Testing as routine part of STD screen
- Community engagement
- Encourage patients to have their partners tested.
- Various forms of outreach in the community in new places; not going the same old places all of the time. Peer outreach (this has been effective for us in reaching new MSM); working through those we are currently assisting to reach new PLWHA.
- Open non-conventional venues to test high risk communities, such as sexual workers, transgender and MSM where they feel safe their identities will be kept confidential.

What strategies have you used, or should be used, to successfully link and retain HIV-positive persons in care?
(n=204)
**Sample of responses provided*

- Ensure that all HIV + clients are referred to the linkage specialists that are trained to engage with these clients to assist them with getting into care by completing eligibility, providing bus passes, etc.
- Peer programs, socials, community events, and collaboration with local, state, federal and national/international advocacy/prevention organizations.
- Cooperation among all provider groups. Centralized linkage phone center available 24/7. All test sites be associated with at least one early intervention service provider with the ability to link after business hours. Follow up procedures for all positive diagnoses that ensure appointments are met and treatment compliance is maintained.
- Three pronged approach to retention in care includes scheduling follow up before they leave the office & providing an appointment card, reminder call 1-2 days before appointment, follow up call for missed appointments.
- One-on-one contact and reaching the client at their site, like home visit and follow ups. Phone calls to remind appointments as well as just to know how they are doing (they will call you back event if you have not call). Once you have a good relation with the client letting them know there are important for you as a human being, not a number they will follow up with care as they can, because they know they can count on you if something happens.
- Peer navigators, "one-stop shops" with multidisciplinary staff, aggressive financial incentives.
- We invite clients to our consortia meetings and then have another client speak on retention and maintaining their own health. This shows clients who may be susceptible to falling out of care to see how others deal with their issues and helps them to reach out and talk to someone about their retention problems.
- The treatment cascade has been helpful in community outreach, this shows there's more than just in care or not. Explaining the benefits of treatment, also more media is available for young minorities to see others who've gone through diagnosis and treatment and that helps.
- Treat positive patients respectfully and provide them with good customer service. Work to improve patient wait times and availability of services to them. Provide information to patients in a way that they understand and engage them in discussion about their care.
- Keep contact information correct and active. Send case manager for follow up visit after 3 consecutive missed clinic appointments.
- We utilize our health navigators and ARTAS programs and through these programs they utilize models to link and retain someone who is recently diagnosed or someone who is HIV positive and seeking care.
- Ancillary services such as mental health, GYN services, neurodevelopmental services, dietary recommendations, social services consultations.

Description of Prevention Interventions and Strategies

Under CDC's funding announcement for HIV prevention programs for health departments, PS-12-1201, DOH is required to implement four required program components that include: 1) HIV testing; 2) comprehensive prevention with positives; 3) condom distribution,; and 4) policy initiatives. In addition to implementing required program components, DOH implements the following two recommended program components under PS-12-1201: 1) HIV prevention interventions for high-risk negatives and 2) social marketing, media, and mobilization. DOH also provides education and information related to PrEP /nPEP. The prevention program implements prevention activities that support core and recommended program components, and continues to maintain a high-impact prevention approach.

Funded HIV prevention programs, regardless of funding source, should implement high-impact prevention programs that include all of the following core program components: 1) HIV counseling and testing; 2) comprehensive prevention with positives programs; 3) condom distribution; and 4) outreach. Programs may also include the following components as recommended program activities to support core program activities: 1) evidence-based interventions for high-risk negatives; and 2) social marketing and community mobilization.

Detailed below are descriptions of core and recommended program components that are currently being implemented in Florida.

Core Program Components

HIV Testing in Non-Healthcare Settings- HIV counseling and testing programs in non-healthcare settings should identify undiagnosed HIV infection using multiple strategies and the most current recommendations for HIV counseling and testing. HIV testing should take place at venues most likely to reach individuals with undiagnosed infections and be targeted towards populations at highest risk for HIV infections (e.g., MSM, transgender persons, and IDUs, regardless of race or ethnicity; and groups such as black and Hispanic men and women at risk, if this is supported by available data and analysis of service gaps).

HIV Testing in Healthcare Settings- HIV testing in clinical settings provides for routine testing in public and private healthcare settings. Based on CDC's 2006 *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, the objectives of HIV testing in clinical settings are to increase HIV screening of patients, including pregnant women, in healthcare settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV. Healthcare settings include, but are not limited to the following: emergency departments (EDs), urgent care clinics (UCCs), inpatient settings, primary care facilities, community health centers (CHCs), health maintenance organizations (HMOs), family planning and reproductive health clinics, college and university student health clinics, pharmacy-based clinics (i.e., clinics located in pharmacy facilities), retail clinics (i.e., clinics located in retail store facilities), STD clinics, TB clinics, other public health clinics, dental clinics, correctional facility clinics, and substance abuse treatment clinics.

Social Networks Strategy-The Social Networks Strategy (SNS) is implemented as a strategy for reaching and providing HIV counseling and testing to persons with undiagnosed HIV infection. Enlisting HIV-positive or high-risk HIV-negative persons (i.e., recruiters) to encourage people in their network (i.e., network associates) to be tested for HIV may prove an efficient and effective route to accessing individuals who are infected or at very high risk for becoming infected with HIV and linking them to services

Comprehensive Prevention with Positives-Comprehensive prevention for positives includes linkages to care and treatment, and interventions to improve retention in care and treatment for individuals previously diagnosed with HIV/AIDS; behavioral interventions and other risk-reduction services for HIV-infected individuals and their sexual or needle-sharing partners; interventions to prevent mother-to-child transmission; and referrals to other social services.

Targeted Outreach for Pregnant Women-The Targeted Outreach for Pregnant Women Act (TOPWA) began in 1999. The mission of TOPWA is to decrease the number of women and babies who contract HIV. HIV-positive, pregnant women enrolled in the TOPWA program receive encouragement to take medications to prevent transmission of the virus to their baby. In addition, they receive assistance with applying for Medicaid, getting prenatal care, and HIV prevention education, condoms, and referrals for family planning services.

MAI-ARTAS-Through funding under MAI, Florida has used the Antiretroviral Treatment and Access to Services (ARTAS) intervention as its model for linking newly-diagnosed persons to care. The overarching goal of the MAI-ARTAS program is to identify HIV-infected minorities not accessing medical care and treatment and link them to services, including ADAP. The MAI-ARTAS program coordinates with county health departments, STD clinics, jails, homeless shelters, mental health and substance abuse clinics and hospitals to receive referrals for individuals recently diagnosed with HIV. There is also coordination between MAI-ARTAS and Ryan White Part C to ensure clients who have fallen out of care are referred to the program. MAI-funded providers coordinate with Ryan White case managers to ensure the client is transferred to a traditional case manager after the client has completed the MAI-ARTAS program, if needed. The MAI-ARTAS program works with many local, state, and federally funded agencies and programs to strengthen the support infrastructure for clients. By working with a variety of partners, MAI-ARTAS ensures an optimal level of care for clients.

Jail Linkage Program- Multiple jail linkage projects around the state provide HIV testing and linkages to inmates in 16 county jails. Persons who test positive for HIV are linked to available medical and support services in their communities upon release. Jails collaborate with community-based organizations in their counties to ensure a link to necessary services for released inmates.

Peer Programs-The prevention program funds peer programs in the following four counties: Alachua, Duval, Orange and Palm Beach. The peer programs operate within the county health department to work in close association with Ryan White eligibility, ADAP and case management. The goal of these programs is to improve client outcomes by helping engage and retain persons living with HIV/AIDS (PLWHA) in care and treatment (linkage, adherence, retention). The peer navigator serves as a role model who provides reliable information, steers

clients in the proper direction to meet their care needs, and helps them overcome barriers to remaining in care. Peers provide HIV-infected clients with guidance and advocacy beyond that which can be provided by case managers and clinicians, through experienced guidance and plain language messages.

Behavioral Prevention Interventions for HIV-Infected Persons- The purpose of behavioral prevention interventions for those living with HIV/AIDS is to address risk behaviors of HIV-infected individuals and their sex or needle-sharing partners, to decrease the likelihood of HIV transmission to uninfected individuals. These interventions also address increasing safer sex behaviors, improving retention in care and treatment, improving medication adherence, and increasing self-efficacy for disclosure of HIV-positive status and condom negotiation. Interventions in this category can be broken up by individual-level (ILI), group-level (GLI), and community-level interventions (CLI). Some examples of ILIs include Partnership for Health and CLEAR (Choosing Life! Empowerment, Action, Results). Examples of GLIs include Healthy Relationships and WILLOW (Women Involved in Life Learning from Other Women). One example of a CLI that could be used with HIV-infected individuals would be an adapted version of Popular Opinion Leader (POL) to address social norms and behaviors among networks of HIV-infected individuals in a given area.

Condom Distribution- Condom distribution (CD) functions as a structural-level intervention by increasing the availability, accessibility, and acceptability of condoms, which leads to increased condom use and potentially, a reduction in HIV/STD acquisition and transmission. Programs should consider integrating CD programs with other HIV prevention strategies and healthcare services as part of a more comprehensive HIV prevention approach.

Outreach- Outreach is defined as an HIV prevention intervention designed to meet potential clients in their own communities and in settings where they live, work, and socialize in order to link them to prevention, testing, and treatment services. One of the primary goals of outreach is to proactively initiate contact with HIV-infected and high-risk populations that are in need of HIV prevention interventions or treatment in order to provide them with health information and increase their awareness of the availability of HIV services within their respective communities.

Active Street Outreach- Active street outreach is usually conducted within a specified area, taking place within a few blocks or in a certain neighborhood or community.

Fixed-Site or Venue-based Outreach- Fixed-site or venue-based outreach activities usually involve setting up a table on a street in front of a frequented corner store, in a well-known bar or hangout, or even working out of a mobile HIV testing unit or storefront. This type of outreach usually requires one staff person to remain at the fixed site and the other to participate in more of an active street outreach capacity.

Drop-Off Site Outreach- Drop-off site outreach usually involves leaving condoms and educational materials with the volunteer distributor. Many outreach workers leave condoms and educational materials with store owners that are partners in HIV prevention; some examples include, barber shops, beauty salons, student organizations on college campuses, corner markets, bookstores, tattoo/piercing parlors, churches, youth recreation centers, gyms and after-school programs.

Internet/Phone Outreach- Internet outreach is defined in the NCSD's *National Guidelines for Internet Outreach* as, "A virtual interaction between an STD/HIV prevention professional, such as an outreach worker, and a person or persons at risk for STDs or HIV, for the purposes of providing STD/HIV related: health information and education, referrals and access to services, recruitment for testing and treatment, and support for reducing risk behaviors." Potential venues for Internet outreach include but are not limited to: social networking sites, which include both dating and niche web sites; chat rooms, instant messaging, e-mail, bulletin/message boards and forums; and lastly, via text messaging.

Recommended Program Components

Behavioral Prevention Interventions for High-Risk Negatives- The purpose of behavioral prevention interventions for high-risk negatives is to reduce risk behaviors that increase the likelihood that someone will become infected with HIV. High-risk behaviors include having unprotected sex and sharing needles used to inject drugs of any kind. These interventions address safer sex skills (condom negotiation, regular use of condoms), social norms and perceptions, behavioral influencing factors, sexual relationship dynamics, the importance of getting tested regularly for HIV, and the acquisition of protective skills. Interventions in this category can be broken up by individual-level (ILI), group-level (GLI), and community-level interventions (CLI). One example of an ILI for high-risk negatives is RESPECT. Some examples of GLIs include VOICES/VOCES and Many Men, Many Voices (3MV). Examples of CLIs include Community PROMISE, Mpowerment and Real AIDS Prevention Project (RAPP).

Social Marketing, Media, and Community Mobilization- Social marketing and community mobilization activities are used to create environments that support high-impact prevention by actively involving community members in efforts to raise HIV awareness, build support for and involvement in HIV prevention efforts, motivate individuals to work to end HIV stigma, and encourage HIV risk reduction where people live, work, play and worship.

PrEP/nPEP-The HIV/AIDS Section's programmatic activities for PrEP and nPEP aligns with allowable activities under the prevention program's primary funding source, the Centers for Disease Control and Prevention's funding opportunity announcement PS12-1201, High-Impact HIV Prevention for Health Departments. Allowable activities for PrEP and nPEP include: planning, education, personnel and other supportive activities; under this source, funds may not be used to purchase medications for either PrEP or nPEP. To date some of our supportive activities include:

- Contracting with the Florida/Caribbean AIDS Education & Training Center to routinely conduct presentations and webinars on PrEP and nPEP
- Medical provider surveys to assess knowledge, attitudes and willingness to prescribe PrEP/nPEP, particularly in Southeast Florida
- Routine updates to the HIV/AIDS Section's website for PrEP/nPEP information and resources (http://www.floridahealth.gov/diseases-and-conditions/aids/prevention/PrEP.html)
- Dissemination of treatment protocols for PrEP/nPEP developed by the HIVAIDS Section's Medical Team

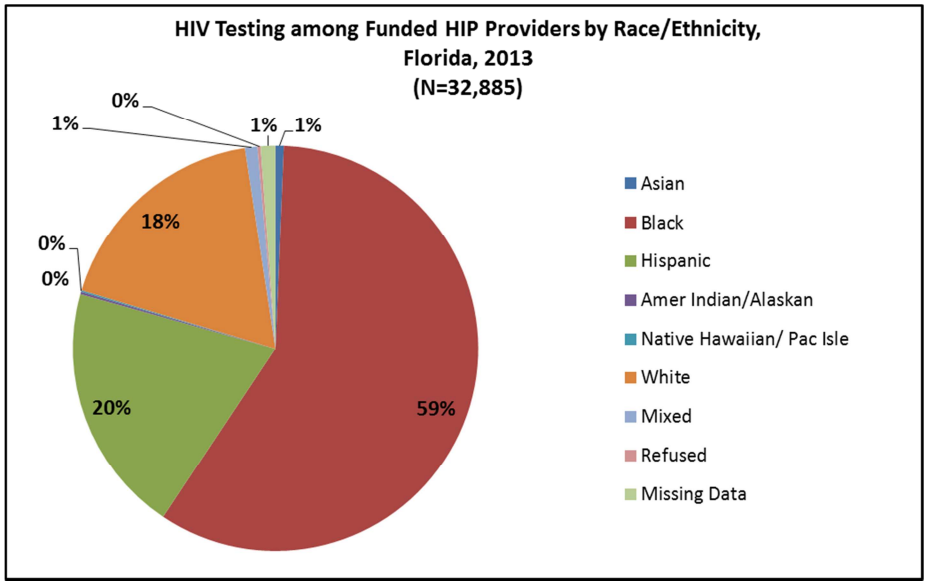
Scalability of Activities

Scaling-up HIV prevention means ensuring that the appropriate mix of evidence-based prevention strategies achieves a sufficient level of coverage, uptake, intensity and duration to have optimal public health effect (UNAIDS Towards Universal Access/Bringing HIV Prevention to Scale). Under CDC PS12-1201, the prevention program began scaling-up HIV prevention activities to ensure that programmatic activities aligned with high-impact prevention (HIP). The prevention program released two Requests for Applications (RFA) to fund community-based organizations (CBOs) to implement HIP. Currently, there are 38 contracts with 28 CBOs funded to deliver HIP services under HIP RFA (12-006) and MSM/Transgender RFA (11-017). In addition to funding CBOs, shifts were made within county health departments (CHD) to realign programs with HIP. Funded CBOs and CHDs are required to provide four core services: HIV testing and linkage, comprehensive prevention with positives, condom distribution and outreach.

Since making the shift to high-impact prevention, the prevention program has scaled-up prevention programs to better target areas and populations most at risk for acquiring or transmitting HIV, and to ensure the best combinations of interventions and strategies are implemented to have the greatest impact on addressing the epidemic. Below is a summary, by core service, of the reach of high-impact prevention programs during the first full year of implementation in 2013.

HIV Testing

HIV testing is conducted in a wide variety of settings, through county health departments (CHDs), private providers and contracts with CBOs. In 2013, a total of 428,203 HIV tests were conducted. Of that total, 2,757 were newly diagnosed; of those 75.6% were linked to medical care. Of the 1,660 previously diagnosed HIV-positive tests, 85.8% were re-engaged in medical care. Of all the HIV tests that were conducted in 2013, 32,885 were conducted by funded CBOs and 188,580 were conducted in CHD sites.



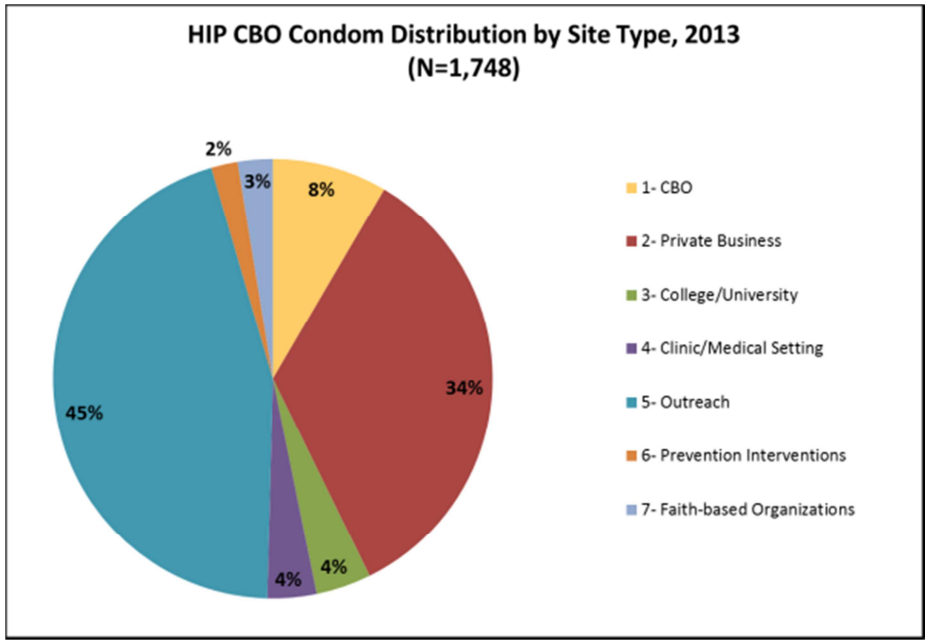
Comprehensive Prevention with Positives

For the first time, as part of required contract activities, funded CBOs were required to implement prevention with positives interventions or strategies. From 2012 to 2013, the total number of individuals reached through interventions delivered by CBOs decreased, however, there was an increase in the proportion of HIV-infected individuals and MSM enrolled, leading to better alignment with HIP. In 2012, HIV-infected individuals made up 1.8% of intervention participants; in 2013, this number increased to 81.5%. MSM comprised 10.0% of intervention participants in 2012; in 2013, this number increased to 40.0%. In 2013, 10,513 HIV-infected individuals were enrolled in prevention for positives interventions, an increase from 649 in 2012. In addition, 3,725 prevention with positives interventions were implemented by CHDs in 2013. There was an overall decrease in the number of individuals participating in interventions for high-risk negatives in 2013. In 2013, 2,619 individuals participated in a high-risk negative intervention in 2013, down from 34,682 in 2012.

Intervention/Strategy	Participants Reached
ARTAS	338
Brief Group Counseling	180
CLEAR	195
CRCS (HIV-positive)	378
Healthy Relationships	190
LIFE	82
Partnership for Health	6,688
Peer Program	2,462
TOTAL	**10,513**

Condom Distribution

The number of condom distribution sites among funded CBOs increased from 226 in 2012, to 1,748 in 2013. In 2013, funded CBOs distributed 246,358 condoms to HIV-infected individuals and 2,608,001 to individuals with high-risk negative/unknown HIV status. The majority of condom distribution occurring within CBOs is happening through outreach activities (45%) and partnerships with local businesses (34%). These numbers are also reflective of the strong Business Responds to AIDS (BRTA) partnerships that have been created in each local area.



Outreach

In 2013, funded CBOs reached 160,293 individuals through face-to-face and Internet outreach, an increase from 73,701 in 2012. A total of 70,813 outreach contacts were made by CHD staff. In addition to traditional outreach, providers have explored other creative ways to reach their target audience - via Facebook, Twitter and other social websites, e.g., Adam4Adam. Methods included posts, tweets and live chats with members of their target populations.

Prevention Program Goals and Objectives

The prevention program has established goals and objectives for each required and recommended program component of CDC PS12-1201. The goals and objectives establish targets and performance measures for HIV program activities over the five-year project period. The following 2012-2016 prevention program goals, objectives and strategies help guide

Florida's HIV prevention program. They provide a framework for monitoring and measuring the progress of Florida's HIV prevention program in reducing new HIV infections, linkage to care and reducing HIV disparities. These goals and objectives consist of annual and five-year goals and objectives that are specific, measureable, achievable and are relevant and time-phased (SMART).

Category A: Required Components

HIV Testing

Goal: Through voluntary counseling and testing, increase the proportion of people who know their HIV status.

Objective 1: By the end of the project period, increase the number of community health centers that offer routine HIV testing to their clients by 30%.

Objective 2: Throughout the project period, ensure that at least 90% of statewide social marketing materials developed contain an HIV testing message.

Objective 3: By December 31, 2012, modify administrative rules, policies, and procedures to streamline HIV testing wherever possible.

Objective 4: By the end of the project period, increase the number of registered HIV test sites by 30% to ensure that testing is readily available.

Objective 5: By the end of the project period, increase the number of faith-based HIV test sites by 20%.

Objective 6: Throughout the project period, maintain the 16 funded HIV testing programs in jails throughout the state.

Objective 7: Throughout the project period, ensure that at least 95% of HIV testing counselors are certified and have completed their annual update certification. Section staffs will conduct a face-to-face meeting to certify all Early Intervention Consultants, as required, so that they can provide this annual update certification for their local areas.

Objective 8: Throughout the project period, ensure that at least 90% of newly diagnosed persons are linked to medical care and partner services and that at least 90% of newly diagnosed pregnant women are linked to prenatal care.

Objective 9: Throughout the project period, evaluate all new testing technologies for possible inclusion in Florida's testing program as they become available.

Objective 10: Throughout the project period, evaluate HIV testing programs to see if hepatitis and STD testing services can be further integrated into those programs.

Comprehensive Prevention with Positives: Linkage to Care

Goal 1: Increase the number of newly identified HIV-infected persons receiving available care and treatment.
Objective 1: Annually, provide education on disease transmission and medical adherence to 1,100 HIV-infected persons enrolled in ARTAS. **Objective 2:** Annually, link 1,100 HIV-infected individuals enrolled in ARTAS to medical care and treatment. **Objective 3:** Annually, ensure at least 80% of persons with newly identified HIV infection are referred to medical care and attend their first appointment within 90 days. **Objective 4:** Establish two Peer Navigation Programs to assist newly identified HIV-infected persons in obtaining medical care and treatment by December 31, 2014.

Goal 2: Increase the number of individuals who are linked to available care and treatment and were previously diagnosed with HIV and have fallen out of care for six months or more.
Objective 1: Offer pre-release planning (PRPP) services to 90% of known HIV-infected inmates in all Department of Corrections facilities annually. **Objective 2:** Annually, link 2,800 pregnant women enrolled in TOPWA to prenatal care, including HIV treatment for HIV-infected pregnant women. **Objective 3:** Annually, have a transmission rate of HIV-infected newborns of less than 1%. **Objective 4:** Annually, refer at least 75% of HIV-infected inmates to medical care upon release from a correctional facility.

Comprehensive Prevention with Positives: Interventions and Strategies

Goal: Increase the number of HIV-infected individuals who receive care and treatment, comprehensive prevention services and treatment adherence education over the five year project period.
Objective 1: Conduct annual training and capacity building assistance for county health department clinics on the use of behavioral and clinical risk screening for HIV-positive persons by collaborating with the Florida/Caribbean AIDS Education Training Center (AETC).

Objective 2: Annually, evaluate the number of county health departments that refer HIV-positive persons and their partners that receive behavioral and clinical risk screening services at their clinics, to behavioral risk reduction interventions if available locally.

Objective 3: Ensure 80% of lead county health departments and funded HIV clinics that provide HIV services are offering HIV-positive persons and their partner's behavioral and clinical risk screening services.

Objective 4: During Years One and Two, pilot the locally-developed Interdiction Project at one additional health department clinic, with the intention of disseminating the program to other health department clinics during the five-year cooperative agreement.

Objective 5: Through a new funding mechanism beginning in January 2013, fund at least 2 community-based organizations to implement comprehensive prevention for positives interventions for a three-year period.

Objective 6: Annually, develop and provide 100% of the health departments and community-based organizations with educational materials related to HIV prevention and treatment adherence for HIV-positive persons.

Objective 7: Increase the number of health department clinics implementing the Partnership for Health intervention by adding one new additional site annually.

Objective 8: Maintain at least one prevention staff representation on the Patient Care Consumer Advisory Group for prevention with positives interventions and activities.

Objective 9: Annually, ensure male and female condoms are readily available at 80% of the targeted healthcare and non-healthcare facilities to all HIV-positive persons and their partners.

Objective 10: Annually, at least 90% of HIV-positive persons enrolled in peer navigation programs will receive treatment adherence education.

Condom Distribution

Goal: Increase statewide condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.

Objective 1: In year one, conduct a statewide condom distribution evaluation to identify additional settings that serve high-risk populations and target areas with high HIV prevalence in need of increased condom distribution.

Objective 2: Annually, increase the number and variety of condom distribution sites through recruitment efforts with local businesses, community-based organizations, faith-based

organizations, healthcare facilities, colleges/universities, and other community partners.

Objective 3: In years one and two, develop and disseminate a statewide condom distribution campaign to include population-specific prevention messages for HIV-positive persons and persons at highest risk for acquiring HIV.

Objective 4: Annually, increase the quantity of male condoms distributed statewide by 15%.

Objective 5: Annually, increase the quantity of female condoms distributed statewide by 10%.

Objective 6: Annually, evaluate the number of outreach activities for condom distribution in areas with the highest HIV prevalence and in settings that serve high-risk populations.

Policy Initiatives

Goal: Develop an HIV prevention policy initiative with efforts to align structures, policies, and regulations to promote optimal HIV prevention, care, and treatment during the five-year funding period.

Objective 1: Utilize external expertise and resources to assist with a comprehensive review of existing structures, polices and regulation by December 31, 2013.

Objective 2: In the first year, develop an HIV prevention policy plan to measure and evaluate policy initiative efforts.

Objective 3: Throughout the grant period review existing structures, polices, and regulations to analyze how they can be changed or enhanced to enable optima HIV prevention, care and treatment services.

Objective 4: Annually, seek ways to enhance structures, polices, regulations to reduce barriers to testing and the facilitation of data sharing.

Category A Required program activities

Jurisdictional HIV Prevention Planning

Goal 1: Develop a jurisdictional HIV prevention plan that includes collaboration and coordination of HIV prevention, care and treatment.

Objective 1: During the first six months of the grant cycle, draft a jurisdictional HIV prevention plan and submit to CDC.

Objective 2: Annually, evaluate the plan goals and objectives conducted.

Goal 2: Monitor the HIV/AIDS epidemic within jurisdictions for program planning, resource allocation, monitoring and evaluation.
Objective 1: Annually review the HIV program's use of epidemic data to ensure jurisdictional planning.

Category A Recommended Program Components

Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV

Goal: Increase the number of HIV-negative persons at highest risk for HIV who are referred to, participate in, and have access to HIV prevention interventions and materials.
Objective 1: Annually, conduct at least one training and capacity building for prevention & training consultants in county health departments to ensure the provision of behavioral risk screening for high-risk HIV-negative persons (and partners) that participate in HIV testing. **Objective 2:** Annually, evaluate the number of county health departments and funded organizations that provide HIV testing to high-risk HIV-negative persons and also provide them with information about local individual and group-level prevention interventions. **Objective 3:** Conduct monthly conference calls with prevention & training consultants to foster information sharing and technical assistance for local HIV prevention interventions and activities. **Objective 4:** Require 100% of the prevention & training consultants to submit annual service delivery plans to ensure gaps in prevention services are being addressed at the county level. **Objective 5:** Annually, identify locally-developed individual, group, and community-level interventions that have the potential to be replicated in other areas of the state and adapted for additional target populations. **Objective 6:** Throughout the grant period, increase by 20% the number of prevention interventions and activities implemented statewide for gay, bisexual, transgender, and other men who have sex with men, with an emphasis on young transgender and MSM of color.

Objective 7: Annually, evaluate the number of funded organizations that provide evidence based interventions and outreach activities for condom and educational material distribution in areas with the highest HIV prevalence and in settings that serve high-risk populations.

Social Marketing, Media, and Mobilization

Goal 2: To ensure social media campaigns result in communities receiving messages, understanding the message clearly and responding positively within the five year project period.

Objective 1: Provide annual support for educational and informational HIV programs (e.g., HIV 101 courses, community presentations, health events) conducted by prevention & training consultants at the local level.

Objective 2: Throughout the grant period, expand by 10% the section's use of media technology (e.g., Facebook, Twitter) for HIV prevention messaging to targeted populations and communities.

Community Mobilization

Goal 1: Strengthen the organizational capacity of county health department staff and community organizations to develop, implement, and evaluate community-level HIV prevention activities.

Objective 1: Conduct annual community mobilization training needs and capacity building assistance assessments for 100% of community-based organizations and health departments providing HIV prevention services.

Objective 2: Annually, conduct a minimum of five internet-based community mobilization capacity building trainings.

Objective 3: During years one and two, increase by 50% the number of users within the community mobilization workstation.

Objective 4: Annually, increase best practice submissions to the community mobilization workstation by 10%.

Objective 5: During year one, increase by five the number of DOH headquarters staff that are trained as community mobilization curriculum trainers.

Objective 6: Annually, ensure that ten county health department staffs are trained to facilitate

local community mobilization curriculum trainings.

Objective 7: Annually, develop and provide 100% of Minority AIDS Coordinators (MAC) and Prevention Training Consultants (PTC) with community mobilization educational materials.

Goal 2: Increase the reach and scope of social marketing and media campaigns to ensure that they result in communities receiving messages, understand messages clearly, and respond positively.

Objective 1: Annually increase the number of unique visitors to the We Make the Change Website by 25%.

Objective 2: Annually, increase the number of text messages received through the We Make the Change text messaging program by 25%.

Objectives 3: Annually increase the number of unique visitors to the Stop the Spread Website by 25%.

Objective 4: During years one and two, increase MSM online marketing by 30%.

Objective 5: Annually, increase the number of callers to the Florida HIV/AIDS Hotline by 25%.

Objective 6: Develop and market media materials that promote at least two community mobilization initiatives.

Goal 3: Promote community-level approaches to HIV prevention in a manner that recognizes diversity, particularly among populations who are most affected by HIV, and to create an environment in which individuals are empowered to address their own community HIV prevention needs.

Objective 1: Annually, increase the number of county health departments implementing community mobilization initiatives (e.g., Sistas Organizing to Survive, L.U.C.E.S, Man-Up) by 80%.

Objective 2: Annually, increase the number of county health department and community-based organizations by 10% who implement in STOP AIDS: It's Everyone's Business.

Objective 3: Annually, increase the number of private businesses by 10% that participate in STOP AIDS: It's Everyone's Business.

Objective 4: Annually, collaborate with at least three private organizations and/or businesses that agree to partner and promote DOH community mobilization initiatives.

Objective 5: During year one, ensure that 100% of Minority AIDS Coordinators receive educational materials and supplies to promote the Latino Testing Initiative.

Objective 6: During year one, DOH will host four community events promoting the Latino Testing Initiative.

Objective 7: Annually, increase the number of new denominations as partners in DOH's faith initiative by three.

Objective 8: Annually, increase the number of church by 25% that participate in National Church Week of Prayer activities.

Objective 9: During year one, conduct community needs assessment activities across a minimum of seven local areas to assess needs and gaps of MSM.

Objective 10: During year one, conduct four focus groups with Florida's Historically Black Colleges and Universities lesbian, bisexual, and transgender student unions to assess the needs of young black MSM and to identify strategies to address the identified needs.

Objective 11: Develop and implement community-level interventions targeting MSM in six Metropolitan Statistical Areas (MSA) in Florida.

Objective 12: Ensure that 100% of county health department staff implements community mobilization activities targeted to MSM.

Objective 13: During year one, convene six community stakeholder meetings with MSM stakeholders in all MSAs in Florida.

Objective14: Annually, convene a minimum of four regional forums with community stakeholders.

Objective 15: Annually, conduct community needs assessments by priority population assessing needs and gaps related to community mobilization.

Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (nPEP) Services

Goal: Annually, increase information available to healthcare and non-healthcare facilities regarding the provision of PrEP and nPEP.

Objective 1: Annually, disseminate educational materials and guidelines on PrEP to 80% of participating healthcare and non-healthcare facilities that serve MSM at highest risk of acquiring HIV infection.

Objective 2: Annually, disseminate educational materials and guidelines on nPEP to 80% of participating healthcare and non-healthcare facilities that serve populations at greatest risk of acquiring HIV infection.

Objective 3: Annually, collaborate with state and national partners to conduct informative annual webinars on the use and implications of PrEP and nPEP in healthcare settings for populations at highest risk for acquiring HIV infection.

Category B Expanded HIV Testing for Disproportionately Affected Populations

Goal: Increase the number of persons who receive HIV testing and the number and proportion of HIV-infected persons who are aware of their infection among populations disproportionately affected by HIV [black and Hispanic men and women, men who have sex with men (MSM), transgender persons, and injection drug users (IDUs)] through routine HIV screenings in healthcare settings and targeted HIV counseling and testing in non-healthcare settings.

Objective 1: Perform at least 105,000 HIV tests in participating healthcare facilities annually.

Objective 2: Perform at least 45,000 HIV tests in participating non-healthcare facilities annually.

Objective 3: At least 90% of Expanded Testing Initiative (ETI) clients are of the target population.

Objective 4: At least 85% of persons who test positive receive their test results.

Objective 5: At least 80% of persons who test positive are linked to medical care and attend their first medical appointment.

Objective 6: At least 80% of persons who receive their positive test results are referred and linked to Partner Services.

Objective 7: Participating non-healthcare sites will maintain at least a 2% rate of newly-identified HIV-positive tests annually.

Objective 8: At least 80% of persons who test positive receive prevention counseling or are referred to prevention services.